MEDICAL PAYMENTS PROCEDURAL MANUAL

SECTION I – MEDICAL PAYMENTS PROCEDURAL MANUAL

1 BILL OVERVIEW

1.1 Medical Bills

Bills generated from providers or injured workers are received by mail, fax, or internally generated. They are taken to ACS via courier for processing. An ACS analyst will recommend payment/denial for each bill based upon Montana State Fund's (MSF) business rules, CPT guidelines, the Administrative Rules of Montana (ARM), and the Utilization and Treatment (U&T) Guidelines. The bill is placed in the Examiner's Tool Box and the Claim Examiner will approve as recommended or modify the bill with other instructions / comments (See Modify Instructions below). Once a bill is approved for payment/denial a check is printed and mailed once ACS receives funding from MSF. An Explanation of Review (EOR) is sent with the payment indicating the charges being paid or denied. **Note: In the case of denial, the injured worker will also receive an Explanation of Review.**

1.2 Modify Instructions

If a Claim Examiner modifies a bill with instructions that are contrary to coding guidelines and reimbursement rules, forward the bill to the Medical Auditors box for review. Refer to ARM 24.29.1533 and ARM 24.29.1432.

1.3 Claim Number Scheme

Montana State Fund uses a 12-digit claim number that is unique to each incident of injury. Some individuals may have more than one claim number with MSF. Providers **MUST** bill with the full 12-digit claim number in order to be processed. All bills with invalid or incomplete claim numbers will be sent to the Medical Auditors box for review.

1.4 Social Security Numbers – Alien Claims

The following guidelines are to be used when creating SSNs for alien claims.

- The first 3 digits called the Area Number cannot be 000, 666, greater than 772, or in the 800-900 series.
- The next 2 digits called the Group Number cannot be 00.
- The last 4 digits called the Serial Number cannot be 0000.

1.5 Documentation Required

- All bills must have records/reports attached. This would include documentation such as graphs and interpretation to support nerve conduction, EKG, and EEG reports, etc. Exceptions are when billing through a Durable Medical Equipment (DME) supply house, Dental bills, pharmacy bills, no show fees and tests for HIV and/or Hepatitis. As long as notes can be obtained from other billing entities, facility bills don't need to have documentation either.
- ICD-9 Diagnosis codes – All providers with the exception of Vocational Rehabilitation and Pharmacy must provide an ICD-9 code(s). Enter all ICD-9 codes provided. If there is no diagnosis present on the bill for Vocational Rehabilitation and Pharmacy, ACS will enter 959.9 as the diagnosis.
- Notes and reports must be signed by the service provider. Acceptable signatures are: Electronic and written signatures, signature stamps, initials and providers that are single practice may have their names in their letter head. Signatures must be legible. Signature on notes must match the name associated with the NPI in box 24J on the CMS 1500.

Exceptions for when the name associated with the NPI in box 24J will not match the signature on the notes are as follows.
    - Locum Tenens – Bills will be accepted when the Q6 modifier is present. Box 31 may indicate locum tenens but isn't required for processing the bill.
    - TC component – Bills will be accepted when a provider bills for the TC component and the NPI and signatures don't match. Box 31 may list the facility name but isn't required for processing the bill.
- A separate CMS 1500 is required for each rendering provider.
- If required information on the bill or medical records are illegible, missing or not allowed, ACS will deny the bill or forward the bill to the Medical Auditor Box if the following exceptions are met.
    - Invalid or missing claim numbers
    - CorVel (CV) bills with re-evaluation requests.
    - CE requests that are outside of the ARM and MSF policies.
    - Lockhart Lien Issues
    - Bill analyst questions bill processing
    - IE Name discrepancies
- If MSF receives a request for a re-evaluation or additional documentation for a bill it may be submitted to ACS via courier or fax.

1.6 Bill Not Substantiated

If the code billed is not substantiated by the submitted documentation, the line should be denied with the most appropriate reason code as the code cannot be changed or reduced. Also, for Modifier issues, follow current procedure in the Medical Payments Procedure Manual.

1.7 Bills ACS will process and pay

- All medical bills from providers and facilities
- Vocational Rehabilitation bills
- Medical Case Management bills
- IME bills
- Dom Care provided by an agency
- Tuition and Books
- Funeral Expenses
- Home/Vehicle modifications

Note: Bills for Tuition and Books, Funeral Expenses and Home/Vehicle modifications are coded by MSF. If the CPT, DX or tax id are missing, ACS will forward these bills to the Medical Auditors box for review.

1.8 ACS Processing Rules

Auto Adjudication Processing Rules:

- Hospital bills: ACS will auto pay fee scheduled amount if payment amount (fee schedule) is less than $1,500.
- General Medical: ACS will auto pay fee scheduled amount if payment amount (fee schedule) is less than $500.
- If the summation of the bill (original and re-eval) for either of these scenarios exceeds the established dollar limit, ACS to fee schedule and **not** auto approve. (The edit is on the fee scheduled amount, not the billed amount.) Should this occur, the bill will be placed in the assigned claim owner's inbox in ETB for approval.

If the claim owner is a CSS, the bill will need to be approved by a Claim Examiner or Claim Specialist as the CSS does not have the authority to approve bills.
If an AA claim assigned to the CSS is then reassigned to a claim examiner in Claim Center, bills will transfer into the claim examiner's inbox in ETB for approval.

MSF Claim Statuses:

- Claim Status: Open or Closed
- Medical Exposure Status: Open or Closed
- Compensability Status: Undecided, Pending, Accepted, or Denied
- Medical Settlement Status: None, Partially Settled, or Settled
- Claim Handling Strategy: Normal or AA

Claim Status Processing Rules:

- If the compensability status is denied, then ACS to recommend zero payment.
- If the compensability status is any value other than denied, then ACS to look at Medical Settlement Status.
    - If the Medical Settlement Status is settled, then ACS to recommend zero payment.
    - If the Medical Settlement Status is anything other than settled, then ACS to fee schedule and look at Handling Strategy.
        - If Handling Strategy is normal then ACS to submit for claim examiner approval.
        - If Handling Strategy is AA, ACS to process according to AA rules.

1.9 Bills MSF Claim Center will process and pay

If ACS receives one of the following, the bill will be sent to the Medical Auditors box for review.

- IE reimbursements
- Medical settlements
- Legal bills
- Fraud / Investigation bills
- Medical Consultant fees
- Dom care provided by family, friends, neighbors, etc. will be paid directly to the IE who will then be responsible for reimbursing the private caregivers
- All IE travel expenses
- Photocopying charges
- Interpreter fees
- Prepayments

1.10 Pharmacy

Effective January 1, 2011, all medication requests with a date of service of 1/1/11 and forward go to Express Scripts for processing and must be transmitted electronically by the dispensing pharmacies. Any paper bills received by ACS will need to be scanned and routed to the Medical Auditors box for further evaluation. ACS will then be asked to process the pharmacy request or delete the bill.

1.11 Medical Benefit Lien (Lockhart)

A 1999 Court decision mandated that where medical benefits have been secured through an attorney, the attorney is entitled to attorney fees (20% or 25% of the fee scheduled amount) on medical benefits paid on behalf of an injured employee. In Claim Center, The CE will list the attorney as a Lockhart Law Firm in parties involved and designate Lockhart Lien on the claim in Loss Details (Applicable Court Cases) with the percentage the attorney is entitled to. Lockhart Lien claims are then flagged in the daily claim feed from Claim Center to ACS and will include the law firm name, address, FEIN, percentage expressed as a decimal to complete the split and a comment indicating how the Lockhart Lien applies to the claim.

ACS will process the bill based on the information sent in the claim feed. The Claim Examiner will review the bill in ETB and either approve the bill or modify it if Lockhart should not be applied.

ACS - Processing Bills with Lockhart Liens

ACS is provided with claim data: attorney name, address, and FEIN; lien percentage; and the information from the comment field. Once the bill is available in ACS it is placed in the examiner tool box for approval/denial. You may verify Lockhart has been added to the claim by locating the bill and hovering over the double arrows - the claim and bill details will display and you can confirm Lockhart is applicable.

- If the Lockhart field is set to Y (yes) the examiner proceeds with approval/denial as normal.
- If Lockhart applies but the indicator is not set to Y (yes)
  - Modify the bill and provide instructions to ACS
  - Update the Applicable Court Case array on the Loss Details page to reflect the Lockhart Lien

To verify Lockhart will be applied to a specific bill, view the EOR. When Lockhart is applicable, all line items must be fee scheduled for attorney lien and all lines must have reason code "Lockhart Lien (80/20)" or "Lockhart Lien (75/25)" applied to them. ACS will create a check payable to the provider and a check payable to the applicable law firm.

ACS will split the payment ***after*** the bill has been approved. Once a payment has processed and the information is loaded into Claim Center you can see a breakdown of the amounts paid to the attorney and the provider by viewing the check details..

*****If Lockhart applies to a claim but a specific bill needs to be processed without the Lockhart lien, make sure to review the bill and the claims examiner will need to modify to 'remove' the Lockhart. This applies to Voc Rehab, Medical Case Management, and IME's.***

Lockhart Re-eval Scenarios

1. **<u>Regular payment (first reevaluation/EOR)</u>**
   ACS will pay provider and attorney based on specified percentage split. Separate checks are issued.

2. **<u>Reevaluation to pay additional</u>**
   ACS will pay provider and attorney based on specified percentage split the "additional" amount due on the 2nd EOR. Separate checks are issued.

3. **Reevaluation to reduce payment**
   ACS will process the 2nd EOR that would reflect the reduction in payments and apply this reduction based on the percentage split for the provider and attorney. The Lockhart Lein reason code needs to be applied (MSF reason code 139). These transactions would create recoveries in Claim Center to collect from both the provider and attorney the amounts due.

4. **Stop/Void on either the attorney or the provider check issued by ACS**
   The stop/void on either check would require manual transactions in Claim Center by MSF. Finance will create a recovery reserve and recovery transactions and collect the funds back from ACS on stop/void checks.

5. **Reissue of a Stop/Void check on either the attorney or the provider check**
   The reissue stop/void on either check would require manual transactions in Claim Center by MSF. The Medical Auditors would need to verify that a recovery transaction has been processed by Finance to Stop/Void the transaction in Claim Center prior to the reissue. The check would need to be manually reissued from Claim Center by the Medical Auditors.

6. **Reevaluation to Deny Lockhart Payment and pay provider at 100%**
   Reevaluation #2 would be to deny the entire bill ~~to zero~~ to recoup all monies paid. The Lockhart reason code will need to be applied to enable both transactions to load to Claim Center (MSF reason code 139).

   Reevaluation #3 would be created to pay the only the provider (no attorney portion) at the recommended allowance on the bill. **Do NOT apply the Lockhart reason code.

7. **Re-evaluation of $0 pay bill on new/existing Lockhart claim**
   a. Bill denied for any reason and ACS analyst removes Lockhart denial reason in error. Re-eval of denied bills cannot be completed. New bill must be processed to apply Lockhart split. ***Analyst must NOT delete the Lockhart denial reason to avoid this scenario.***
   b. Lockhart is assigned to a claim after bills have been processed and denied. Re-eval of denied bills cannot be completed. New bill must be processed to apply Lockhart split.

1.12 Payments/Refunds

HB 110 - 39-71-107. Insurers to act promptly on claims -- in-state claims

5(c) An insurer that without good cause neglects or fails to pay undisputed medical bills on an accepted liability claim within 60 days of receipt of the bill may be assessed a penalty of not less than $200 or more than $1,000 for each bill that is the subject of a delay as provided in this subsection (5)(c).

2 FREQUENTLY USED ACRONYMS

AR	Accounts Receivable
ARM	Administrative Rules of Montana
ASC	Ambulatory Surgery Center
CA	Certified Acupuncturist
CC	Claim Center
CMS	Center for Medicare and Medicare Services
CMS	Claim Management System (old bill payment system)
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
DOLI	Department of Labor & Industry
DOS	Date(s) of Service
DX	Diagnosis
EOR	Explanation of Review
ERD	Employment Relations Division
FEIN	Federal Employer Identification Number (Tax ID)
FY	Fiscal Year
HCFA	Health Care Finance Administration
HCPCS	HCFA Common Procedural Coding System
HH	Home Health
HIPAA	Health Insurance and Accountability Act
IE	Injured Employee
MCA	Montana Codes Annotated
MCM	Medical Case Management (Manager)
MCO	Managed Care Organization
MFFS	Montana Facility Fee Schedule
MHS	Montana Health Systems
MMI	Maximum Medical Improvement
MNSF	Montana Non-facility Fee Schedule
MSF	Montana State Fund
MT	Massage Therapy
NP	Nurse Practitioner
NPI	National Provider Identifier
O2	Oxygen
OT	Occupational Therapy
PA	Physician Assistant
PPO	Preferred Provider Organization
PT	Physical Therapy
RBRVS	Resource Based Relative Value Scale
RN	Registered Nurse
RVP	Relative Value for Physicians
RVU	Relative Value Unit
TENS	Transcutaneous Electrical Nerve Stimulator
TX	Treatment
UB92/UB04	Uniform Billing hospital form
U&T	Utilization and Treatment

3 BILL REASON CODES

ACS will send an Explanation of Review (EOR) to the medical provider after a bill has been approved by the claim examiner. The EOR will include MSF "reason codes" that defines how payment is determined.

MSF Code	Description
050	Payment pending investigation for compensability
067	Please submit records so payment can be considered.
070	Requested information not provided or incomplete
073	Claim Denied - Not Compensable
085	Claim in litigation
090	Balance due not payable
100	Modifier 81-Documentation shows surg asst service
101	Modifier 51-Multiple procedures performed
102	Modifier 50-Bilateral procedure performed
104	Modifier 26-Documentation shows prof component
107	Procedure insufficiently identified or quantified
108	Modifier -52 identifies a reduced/eliminated service/procedure by election of physician.
109	Modifier -78 identifies a return to operating room for a related procedure during post-op period.
11	Service partially unrelated to claim
114	Operative report needed to review charges
115	Procedure not medically necessary
116	Timed procedure - Submit treatment time
118	Testing results/report needed to review charges
12	Not a valid PT or OT code for Montana
120	Procedure unrelated to diagnosis
125	Procedure unrelated to the compensable work injury
130	Service(s) unsubstantiated by documentation provided
132	Denied-incorrect procedure code
134	Denied-invalid CPT/HCPCS/ADA/NDC code
135	Reduced per Administrative Rules of Montana
137	Asst surgeon not warranted for service provided
139	Lockhart benefit lien
142	Invalid claim number for this injury
144	No allowance for freight
150	Denied per insurance carrier decision
153	Denial for 60 month law
154	Illegible report
158	The rental item has been purchased

BILL REASON CODES cont.

MSF Code	Description
161	Rental charges have been applied
162	Rental charges apply to purchase price
163	Modifier missing
173	Code 97799 requires a separate written report
175	Code 99080 requires a separate written report
177	Modifier 27 / TC represents the technical component of services performed
180	Documentation for each DOS needs date &/or svc provider signature
197	Included in global fee of surgical procedures
198	99140 is warranted only if delay causes significant threat to life or body part
2	Denied-unrelated service
224	Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned
225	Services provided by a Surgical Team. Reimbursement based on the Global fee for a Surgical Team.
234	Prolonged services of less than 16min total duration on a given date is not separately reimbursable.
247	Staged/related procedure performed by same physician during post-op period
253	Units billed exceed units allowed per fee schedule
254	Total duration of prolonged servs/codes less than 31 min not reported separately.
276	Time requirements for this CPT code were not met
293	Review of previously interpreted diagnostic tests are not separately reimbursable
299	State specific cost to charge ratio/payment adjustment factor applied
304	Submit supply house/mfr invoice for additional payment consideration
33	Provider not authorized on claim
333	Not authorized
35	Court override
354	Procedure code 22851 should only be used once per interspace
355	Add-on codes are always performed in addition to the primary service procedure, and must never be reported as a standalone code
360	Allowance is limited to one unit
380	Recommendation is based on attached invoice
382	CPT/HCPCS code missing
39	Non-accept or disputed initial compensability
393	Provider specialty required.
396	The attached bill is not subject to the application of the Lockhart Lien split.
397	Lockhart Lien (80/20)
398	Lockhart Lien (75/25)

BILL REASON CODES cont.

MSF Code	Description
41	Payment reduced due to subrogation agreement
43	Fee schedule applied
46	Non-reimbursable service-Billable to injured worker
48	Durable medical equipment purchase not approved
503	Allowed fee decreased due to contractual agreement
507	Priced per PPO/Contract Agreement
511	Non-licensed surgical assist does not warrant a fee
524	Recommended allowance per Insurer decision
533	This service exceeds the procedure limit rule established
544	Allowed at Invoice cost plus 30%
559	Allowance is based on invoice cost + 15%
572	This spinal injection procedure must be billed with a fluoroscopy procedure.
6	Non-reimbursable service-Not billable to injured worker
610	Submitted doc for a new pt did not meet the 3 key components lacking in the level of history
611	Submitted doc for a new pt did not meet the 3 key components lacking in the level of examination
612	Submitted documentation for a new pt did not meet the 3 key components lacking in the level of medical decision making
613	Submitted doc for a new pt did not meet the 3 key components lacking in the level of history & exam
614	Submitted doc for a est pt did not meet the 2 key components lacking in the level of history & exam
615	Submitted doc for a est pt did not meet the 2 key components lacking in the level of exam & med dec
640	Qualifying Circumstance codes must be billed in conjunction with Anesthesia to receive reimbursement
65	Injured worker did not keep appointment
658	Provider billing as Co-Surgeon. Exposure is inclusive in value of anterior lumbar fusion.
665	Designated Treating Physician reimbursement (110% of fee schedule)
668	Referred Health Care Provider reimbursement (90% of fee schedule)
669	Disallowed service per U&T Guidelines
670	Disallowed procedure/service per Administrative Rules of Montana
671	No additional payment recommended
672	Payment of this bill does not constitute acceptance of conditions/injuries not related to the injury of record. Treatment for unrelated conditions should be addressed at a separate appointment.
675	Overpayment - recoupment request
676	Denied-maximum medical reached

BILL REASON CODES cont.

MSF Code	Description
677	Denied-date of service prior to date of injury
679	Adjustment to previous charge
680	Denied-over the counter medication
681	Denied-unnecessary service
682	Treatment exceeds U & T Guidelines
683	Denied-authorization expired
684	Denied-medical record copy fee for current treatment not separately reimbursable.
685	Denied-eye care. No change in vision
686	Denied-surgical assistant not allowed for this procedure
687	Refund request-paid to incorrect provider
689	Overpayment-check returned by provider
690	Facility fee inapplicable. Clinic services not provided in a Medicare certified Provider Based Clinic or a designated CAH.
700	Co-Surgeons (Mod -62) payment rule not recommended for these procedures.
701	Team Surgery (Mod -66) payment rules not recommended for these procedures.
702	Liability for this claim has ***not*** been accepted by Montana State Fund (MSF). Payment for medical services is being made under full reservation of rights. If liability is subsequently denied, MSF may request a full refund of the payments made.
71	Modifier -47 identifies regional and general anesthesia provided by a surgeon.
72	Modifier 54-Documentation shows surgical care only
73	Incorrect use of modifier
74	Modifier -57 indicates initial decision to perform surgery
75	Modifier 55-Documentation shows post-op mgmt only
76	Modifier 56-Documentation shows pre-op care only
77	Modifier -79 Unrelated Procedure or service by the same physician during the post-op period.
79	Modifier -24 identifies an unrelated evaluation and management service by the same physician during a postoperative period.
800	This recommended payment is a result of your inquiry and is in addition to a recommendation previously made by CorVel
801	This procedure was previously reviewed by Corvel and paid by the claims administrator. We agree with Corvel s original review.
81	Modifier -66 identifies team surgery.
82	Modifier -77 indicates a repeat procedure by another physician.
83	Modifier -76 indicates a repeat procedure by same physician
84	Modifier -74 identifies a discontinued procedure after the administration of anesthesia.
81	Modifier -66 identifies team surgery.
82	Modifier -77 indicates a repeat procedure by another physician.

BILL REASON CODES cont.

MSF Code	Description
83	Modifier -76 indicates a repeat procedure by same physician
84	Modifier -74 identifies a discontinued procedure after the administration of anesthesia.
86	Modifier -73 identifies a discontinued procedure prior to the administration of anesthesia.
87	Modifier -59 represents a distinct procedural service.
88	Modifier -90 identifies laboratory procedures are performed by a party other than the treating or reporting physician.
897	Missing reimbursement data for specified code or facility
898	A portion of the billing is missing, Please resubmit
899	Claim contains incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
93	Not a valid chiropractic code for Montana
94	Modifier -82 identifies an assistant surgeon when a qualified resident surgeon is not available.
95	Modifier (22) Unusual Procedural Services
98	Modifier 25 represents significant separately identifiable services
980	Reimbursement based on 75% of billed charges.
986	Per MT Fee Schedule, Critical Access Hospital reimbursement is at 100% of billed charges.
99	Modifier 80-Documentation shows asst surgeon serv
A01	Treatment not authorized
A02	Rental to purchase price has been met; no further payment recommended
A03	Not considered a separate procedure/bundled in another service
A04	DOS billed does not match DOS in notes
A05	Provider signature on bill does not match signature in submitted documentation
A06	Drug/Supplies not identified in submitted documentation
A07	Place of Service code missing
A08	Non-reimbursable service for Facilities
A09	Physician cannot bill a technical component
A10	Facility cannot bill a professional component
DUP	Duplicate Charge
IQA1	Recommended allowance is considered fair & reasonable based on an analysis performed in your geographical area
IQA2	Reduction is in no way associated with a PPO contract
IQA3	For a detailed explanation on the reduction, please visit our secure website at https://www.dataisight.com/acscompiqprovider/
MSF	Denied - Not an MSF PPO
R0	Multiple procedure/1st procedure

BILL REASON CODES cont.

MSF Code	Description
R13	Visit falls within global surgery followup period
R17	Primary procedure code not found in history
R20	Procedure code billing restricted/once per visit
R32	Procedure considered experimental/investigational
R38	Included in another billed procedure
R41	Procedure not in provider's scope of practice
R50	Charge included in facility fee
R52	Multiple procedure reduction applies.
R53	Multiple procedure reduction does not apply.
R54	This service is an Add-on procedure and is excluded from the multiple procedures rule reduction
R75	Adjuster preauthorization required
R76	CCI-bundled in another billed procedure
R78	CCI-anesthesia included in surgical procedures
R79	CCI-standards of medical/surgical practice
R80	CCI-HCPCS/CPT procedure code definition
R81	CCI-HCPCS/CPT coding manual instruction/guidelines
R82	CCI-HCPCS/CPT separate procedure definition
R83	CCI-gender specific procedures
R84	CCI-most extensive procedures
R85	CCI-sequential procedures
R86	CCI-with versus without procedures
R87	CCI-Laboratory panel
R88	CCI-mutually exclusive procedures
R89	CCI-misuse of column 2 code with Column 1 code
R92	Radiology service unrelated to reported injury
R93	National Correct Coding Initiative edit - either mutually exclusive of or integral to another service performed on the same day.
RB7	Procedure code invalid for ASC

4 COST CATEGORIES

Expense Categories Rules

- All inpatient hospital visits are coded to expense 102.
- Code outpatient hospital bills by line by code (actual service provided), any code/service falling outside or that doesn't fit under another expense code, code as HO except if ASC.
- Procedure codes are coded to the expense code to which they are listed.
- If the above rules don't apply, then expense code is defaulted to Physician and Surgeons.

Priority	Pay Code	Description	Variable 1 (Column D)	Variable 2 (Column E)	Comment
1	102	Inpatient Hospital	Bill type of HI	-	
2	112	Diagnostic/ X-ray/Lab	Procedure Code in range: 70010 - 89999 or ATP01 - ATP99; G0008 - G0010; G0027, G0101 - G0107, G0120 - G0124, G0141 - G0148, G0202 - G0235, G0306, G0307, G0328, G0416 - G0419, G0430 - G0431; P0001 - P9999; Q0091, Q0111 - Q0115; Q9958 - Q9967, R0001 - R9999	Revenue code in range: 300 - 319 or 320 - 359 or 400 - 409 or 610 - 619	Column D *or* E is true
3	114	Ambulance/ Airlift	HCPCS code in range: A0001 - A0999	Revenue code in range: 540 - 549	Column D *or* E is true
4	151	Home/Vehicle Modifications	Procedure code of E1499	-	
5	117	Other Medical Supplies	Procedure code in range: A4206 - A9300 or E0720 - E0770 or V2020 - V5299	Procedure code one of the following values: E1399	Column D *or* E is true
6	116	Prosthetics/ DME	Procedure code in range: A9900 - A9999 or E0100 - E0719, E0771 - E9999 or K0001 - K0899 or L0100 - L9900, or Q4001 - Q4051, Q4100 - Q4116	Revenue code in range: 290 - 299	Column D *or* E is true
7	110	Licensed Long Term Care/Home Health	Procedure code one of the following values: H5190, HHHA1, HHHA2, HHHM1, HHLN2, HHOT1, HHPT1, HHRN1, HHRN2, HHSS1, HHST1, RN1TR, HA1TR, PT1TR, ST1TR, OT1TR, RN2TR, LN2TR, HA2TR	Revenue code in range: 570 - 599 or 640 - 649 or Bill Type SNF	Column D *or* E is true
8	110	Licensed Long Term Care/Home Health	Line Pay Code of 110	Procedure code of A9200	Column D *and* E are true
9	105	Chiropractor	Provider Specialty of CHI	-	

COST CATEGORIES cont.

Priority	Pay Code	Description	Variable 1 (Column D)	Variable 2 (Column E)	Comment
10	105	Chiropractor	Bill type of CHI	Procedure code in range: 97010 - 97799; 98940 - 98943; 99080, 99199, 99201 - 99205 or 99211 - 99215; 99241 - 99245 or 99358-99359, 99455 - 99456; or 99499 or MT001	Column D *and* E are true
11	107	Physical Rehabilitation	Procedure code in range: 96300 - 96301 or 97001 - 97814 - or - G0129; G0151-G0153; and G0157-G0161 and G0237-G0239 Procedure code of H5300	Revenue code in range: 420 - 424 or 430-439	Column D *or* E is true
12	103	Emergency Room/ Outpatient Hospital	Bill type of HO	-	
13	108	Vocational Rehabilitation	Procedure code one of the following values: ERTW, EWLA, EWLA1, EWLA2, JA008, JAALT, OFBAS, OFEXT, OFJAS, OFLIT, OFSIF, OFSPL, OFSSD, OFWLA, PLACE, VRLIT, VRMON, VRPLN, VRREV, VRSIF, VRSPL, VRSSD, VRTRV, VRTST, VRTRM, VRTRT, VRTRH	Procedure code in range: INC01 - INC08	Column D or E is true
14	109	Medical Case Management	Procedure code in range: LCP01 - LCP02 or RNCM1 - RNCM2 , or MCMTR	-	
15	109	Medical Case Management	Line Pay Code of 109	Procedure code of A9200	Column D and E are true
16	118	IME/Review Panels	Procedure code one of the following values: DCFEE, IME01, IMENO, MDF01, MDF02, MDFEE, MDFNO, 99499	Column D is true	
17	118	IME/Review Panels	Line Pay Code of 118	Procedure code of A9200	Column D and E are true
18	115	Psychological	Procedure code in range: 90801 - 90911 or 96101 - 96155 or T1006-T1007 and T1012	-	Column D is true
19	113	Drugs/ Pharmacy	All NDC Codes	Procedure code in range: J0120 - J9999	Column D *or* E is true
20	104	Surgery Center	Bill type of ASC	-	

COST CATEGORIES cont.

Priority	Pay Code	Description	Variable 1 (Column D)	Variable 2 (Column E)	Comment
21	111	Unlicensed Domiciliary Care	Procedure code of DOM01	-	
22	106	Private Duty Nurse Care	Procedure code in range: S5497 - S5523 or S9122 - S9379 or S9490 - S9810 or T1000 - T1004 or T1021 T1030 - T1031 or 99503 - 99602 or G0151 - G0164	-	
23	119	Mortician/ Burial	Provider Specialty of M1000	-	
24	150	Schools and Retraining	Provider specialty in range: H5170 - H5174	-	
25	101	Physicians, Surgeons and Other	DEFAULT		

5 INTERNAL CODES

Codes that have been developed in-house to identify specific services not otherwise identified in RVP or CPT to meet the Administrative Rules of Montana and MSF Business Rules.

Code	Description	Used By:
A9200	Mileage (travel)	Prevailing State Rate
A9200	Provider travel reimbursement	MSF Review
DCFEE	Chiropractic fee	Contracted vendors only
E1499	Large equipment, non-DME, remodeling	
E1399RR	INTERFERENTIAL (IFFY II)	Contracted vendors only
E1399NU	NTERFERENTIAL (IFFY II	Contracted vendors only
ERTW	Early Return to Work Coordination (expires 6/30/12)	Contracted vendors only
EWLA	Employability and Wage Loss Assessment	Contracted vendors only
EWLA1	Employability and Wage Loss Assessment – Background only	Contracted vendors only
EWLA2	Employability and Wage Loss Assessment – Assessment only	Contracted vendors only
HHHA1	Home Health aide visit	Contracted vendors only
HHHA2	Aide visit	Contracted vendors only
HHLN2	Home Health LPN visit – new code as of 7/1/04	Contracted vendors only
HHPT1	Home Health Physical Therapy, Skilled, Per Visit	Contracted vendors only
HHOT1	Home Health Occupational Therapy, Skilled, Per Visit	Contracted vendors only
HHRN1	Home Health Registered Nurse, Skilled, Per Visit	Contracted vendors only
HHRN2	Home Health Registered Nurse, Private Duty, Per Hour	Contracted vendors only
HHST1	Home Health Speech Therapy, Skilled, Per Visit	Contracted vendors only
HA1TR	Home Health Aide, Skilled-travel, Per Hour	Contracted vendors only
HA2TR	Home Health Aide, Private Duty, Travel, Per Hour	Contracted vendors only
H5170	Other reasonable and necessary retraining expenses	
H5171	School tuition	
H5172	School fees (other than tuition)	
H5173	School books and supplies	
H5174	Computer, computer equipment	
H5190	Nursing care (home)	
H5300	Health club dues	
IME01	Administrative Charges for IME Services (1 fee per IME)	Contracted vendors only
IMENO	Administrative Fee, No-Shows & Cancellations (1 fee per IME)	
INC01	ERTW at TOI job & TOI wage within 30 days of Phase II referral	Contracted vendors only
INC02	Successful SSDI Application	Contracted vendors only
INC04	ERTW at mod/alt job within 30 days of Phase II referral – old	Contracted vendors only
INC05	ERTW at mod/alt job within 60 days of Phase II referral – old	Contracted vendors only

INTERNAL CODES cont.

Code	Description	Used By:
INC06	ERTW at mod/alt job within 90 days of Phase II referral – old	Contracted vendors only
INC07	Return to TOI wage following OJT training, Phase IV, VI – old	Contracted vendors only
INC08	Successful RTW for IE deemed perm total, Phase IV, VI – old	Contracted vendors only
JAALT	Modified and Alternative JA w/time of injury employer and Modified and Alternative Job Analysis – old	Contracted vendors only
JA008	Time of injury job analysis – old	Contracted vendors only
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified	
LCP01	Life care plan, simple – old	Contracted vendors only
LCP02	Life care plan, comprehensive – old	Contracted vendors only
LN2TR	Home Health LPN, Private Duty- Travel, Per Hour	Contracted vendors only
M1000	Mortician/Burial Costs ($4,000.00 maximum payment - use with diagnosis code 959.9)	
MCMTR	Travel, Per Hour	Contracted vendors only
MDFEE	Physician fee (medical, psych, neuro psych, etc)	Contracted vendors only
MDFNO	No-Shows and cancellations:	Contracted vendors only
MDF01	Additional Questions (submitted after exam)	Contracted vendors only
MDF02	Multivolume files or multi-claim examination	Contracted vendors only
ME100	Medical Expenses (use this code for environmental studies)	
MT001	Services provided under old code 97799 (MT code); Unlisted Physical Medicine/Rehab Procedure	
OFBAS	Old Fund basic file review, 0-5.0 hours	Contracted vendors only
OFEXT	Old Fund extended file review	Contracted vendors only
OFLIT	Old Fund litigation	Contracted vendors only
OFJAS	Old Fund job analysis, TOI or alternative	Contracted vendors only
OFSIF	Old Fund subsequent injury fund registration	Contracted vendors only
OFSSD	Old Fund Social Security Disability registration	Contracted vendors only
OFSPL	Old Fund: Customized/Special Services	Contracted vendors only
OFWLA	Old Fund employability & wage loss assessment	Contracted vendors only
OT1TR	Home Health Occupational Therapy, Skilled-Travel, Per Hour	Contracted vendors only
PLACE	Job placement services	Contracted vendors only
PLAC1	Additional Job Placement Assistance 1	Contracted vendors only
PLAC2	Additional Job Placement Assistance 2	Contracted vendors only
PLAC3	Additional Job Placement Assistance 3	Contracted vendors only
PLNDEV	Plan Completion	Contracted vendors only
PT1TR	Home Health Physical Therapy, Skilled-Travel, Per Hour	Contracted vendors only
RNCM1	Nurse case management fee	Contracted vendors only

INTERNAL CODES cont.

Code	Description	Used By:
RNCM2	Nurse case management, additional hours	Contracted vendors only
RN1TR	Home Health Registered Nurse, Skilled –Travel, Per Hour	Contracted vendors only
RN2TR	Home Health Registered Nurse, Private Duty-Travel, Per Hour	Contracted vendors only
ST1TR	Home Health Speech Therapy , Skilled – Travel, Per Hour	Contracted vendors only
SARTW	Stay At Work/Return to Work	Contracted vendors only
VRLIT	Litigation	Contracted vendors only
VRMON	RTW/Training plan monitoring	Contracted vendors only
VRPLN	Initial Assessment/Preliminary Report	Contracted vendors only
VRREV	Revision of RTW plan/completion of alternate plan	Contracted vendors only
VRSIF	Subsequent Injury Fund Registration	Contracted vendors only
VRSSD	Social Security Disability Registration	Contracted vendors only
VRSPL	Customized/Special Services	Contracted vendors only
VRTRH	Lodging – paid at prevailing state rate	Contracted vendors only
VRTRM	Meals paid at prevailing state rate – must specify each meal	Contracted vendors only
VRTST	Vocational Testing	Contracted vendors only
VRTRV	Mileage	Contracted vendors only

6 PLACE OF SERVICE CODES

Code	Place of Service	Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (eg: emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Immediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with share living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventative and primary care services.

PLACE OF SERVICE CODES cont.

Code	Place of Service	Description
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non surgical) and rehabilitation services by, or under, the supervision of physicians to patient admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and non surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides residents with skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance-Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick and injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically under served area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility - Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

PLACE OF SERVICE CODES cont.

Code	Place of Service	Description
53	Community Mental Health Center (CMHC)	A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; ➢ 24 hour a day emergency care services; ➢ Day treatment, other partial hospitalization services, or psychosocial rehabilitation services; ➢ Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and ➢ Consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility, which primarily provides health, related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drugs) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients which physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically underserved area, which provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Unlisted Facility	Other service facilities not identified above.

7 BILLING FORMS

7.1 CLEAN CLAIM

A clean claim is defined by Medicare as a claim which has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

The elements for a clean claim have been required for some time, beginning January 1, 2011 medical bills will be denied if elements are missing that are necessary to process for payment. The required elements must be complete, legible and accurate. The following elements are required to meet the test for "Clean Claim" status for MSF:

7.2 CMS (HCFA) 1500 GENERAL MEDICAL

(*See the CMS website for form information:* https://www.cms.gov/cmsforms/)
The CMS (HCFA) is used when billing for general medical services. The required information is as follows:

Box #	Description
1a	**Required** Insured's ID number will be the full 12 digit claim number of the injured worker. (Note: the claim number can be listed anywhere on the form.) **Processing:** If claim number is missing or invalid, the bill will be forwarded to the Medical Auditor Box. MSF will modify the bill to indicate which claim to process the bill on or instruct to have the bill deleted and destroyed.
2	**Required** Injured Employee's name
3	**Required** Injured employee's date of birth/sex
5	**Required** Injured employee's address
10	**Required** "Is patient's condition related to…?
11	Claim number – OPTIONAL as it should also be entered in 1a
12	The patient (injured employee) or authorized representative must sign/date the form unless there is a signature on file, then "Signature on file" is sufficient
14	**Required** Accident/Injury Date
17a	Referring Provider Taxonomy (**if applicable**) – input ZZ in first box and 10-character taxonomy code without spaces in the second box
17b	Referring provider NPI# (**if applicable**), input 10-character NPI number
21	**Required** ICD-9 diagnosis code(s) Note: for Vocational Rehabilitation, this box is optional; enter 959.9 for voc rehab bills.
24A	**Required** Date(s) of service
24B	**Required** Place of service code
24D	**Required** Procedures, Services or Supplies – enter appropriate CPT, HCPCS, Montana Only or contracted code(s). If using an unlisted code etc, also enter description.
24E	ICD-9 code or number from Box 21
24F	**Required** Service charge/fee billed for each line item/code
24G	**Required** # Days or unit(s) – enter the number of units for each line item/code
24I	ID Qualifier – 'Blank' and preprinted 'NPI' spaces. Blank space should be populated with ZZ for taxonomy code listed in 24J.
24J	**Required – if applicable (exceptions are Vocational Rehabilitation, DME, ambulance, ASCs, labs, MRI centers, MCM, infusion therapy, non-medical providers).** Rendering provider ID# - If top space is 'blank', 24I is populated with ZZ then enter 10-digit taxonomy code in 24J (top space). N**ote: MSF# no longer valid**. On the bottom line, enter the NPI number in the corresponding space after preprinted

	'NPI' in 24I. **Processing:** For Professional bills, if the NPI is not supplied by provider, the bill will be denied with reason code "Claim contains incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information" and nothing will be sent to MSF in the file feed. For facilities that are billing on a CMS-1500, ACS should send the NPI in Box 33 as the rendering provider. ACS will populate the rendering taxonomy based on the NPI number chosen from either box 24J or 33 per the NPPES database.
25	**Required** Federal Tax ID number – enter the tax ID or SS# of the billing entity
28	**Required** Total Charges
31	Signature of Physician or supplier, including degrees or credentials. **Processing:** ACS will send the name associated with the Rendering NPI in box 31 or the Billing NPI in box 33 per the NPPES database. See box 24J instructions for processing details.
32	**Required – if applicable (exceptions would be Ambulance, POS 12, DME and Voc Rehab).** Name and address of facility where services were rendered (cannot be PO Box).
32a	**Required – if applicable (exceptions would be Ambulance, POS 12, DME, MCM, non-medical providers and Voc Rehab providers who are considered "consultants).** Service Facility Location NPI – enter 10-character NPI number. **Processing:** If the NPI is not supplied by the provider, the bill will be denied with reason code "Claim contains incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information". If the bill is an exception, process bill. Do not populate this field if not on form – instead leave blank.
32b	Service Facility Location Taxonomy – input ZZ and 10-character taxonomy code without spaces. **Processing:** ACS will populate the service facility taxonomy based on the NPI number given in box 32a per the NPPES database.
33	**Required** Physician's, suppliers billing name, address, zip code.
33a	**Required – if applicable (exceptions would be Ambulance, POS 12, DME, MCM, non-medical providers and Voc Rehab providers who are considered "consultants).** Billing Provider NPI # - input 10-character NPI number. **Processing:** If the NPI is not supplied by the provider, the bill will be denied with reason code "Claim contains incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information". Do not populate this field if not on form – instead leave blank.
33b	Billing Provider Taxonomy – input ZZ and 10-character taxonomy code without spaces. **Processing:** ACS will populate the billing provider taxonomy based on the NPI number given in box 33a per the NPPES database.

7.3 UB 04

UB04 (*See the CMS website for form information:* https://www.cms.gov/cmsforms/)

Form Locator	Description
1	**Required** Billing provider name, and physical address.
2	**Required – if applicable (Box 1 is a PO Box)** Pay to address if different than field 1.
4	**Required** Type of bill –enter the three or 4 digit code that indicates the type of bill you are submitting.

5	**Required** Federal Tax Number
6	**Required** Statement covers period – enter the beginning and ending service date(s) of the period covered by the billed.
8	**Required** Patient name – enter last name, first name and middle initial.
9a-d	**Required** Patient address
10	**Required** Date of birth
11	**Required** Sex ("M" for male, "F" for female or "U" for unknown.
12	Admission/start of care date – enter the date the member was admitted for inpatient care, or the date of the outpatient service.
13	Admission hour – situational. Enter the two-digit hour during which the patient was admitted for inpatient care.
14	Admission Type – enter the code indicating the priority of this admission/visit.
15	Source of Admission – enter the appropriate source of admission code
16	Discharge hour – enter the code that indicates the discharge hour of the member from inpatient care.
17	Patient discharge status – enter the appropriate patient discharge status code
42	**Required** Revenue code(s) – enter the 4 digit Revenue code beside each service described in column 43.
43	**Required** Description – enter a brief description that corresponds to the revenue code in column 42.
44	**Required** HCPCS/Rates – for outpatient services, enter appropriate CPT/HCPCS code, where applicable. On inpatient bills, enter the accommodation rate
45	**Required** Service date – enter the date of service; for outpatient claims, enter the date on which each service was rendered.
46	**Required** Units of service
47	**Required** Total Charges – the sum of the total charges for the billing period for each revenue code (FL42)
Line 23	**Required** Total Charges – Enter the claim total.
56	**Required** Billing Provider NPI – input 10-characer NPI number. **Processing:** If the NPI is not supplied, the bill will be denied with reason code "Claim contains incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information". Do not populate this field if not on form – instead leave blank.
58	**Required** Insured's name
60	**Required** May enter the patient's claim number here. (Note: the claim number can be listed anywhere on the form.)
67A-Q	**Required** Principal diagnosis code and present on admission and any other diagnosis
69	Admitting Diagnosis
74	**Required - if applicable** Principal procedure code – situational.
76	**Required** Attending Provider NPI – input 10-character NPI number. **Processing:** If the NPI is not supplied, the bill will be denied with reason code "Claim contains

	incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information". Do not populate this field if not on form – instead leave blank.
77	Operating Provider NPI **(if applicable)** – input 10-character NPI number
78-79	Other Provider's NPI **(if applicable)** – input 10-character NPI number
81a	Billing Provider Taxonomy – input B3 in the first box and 10-character taxonomy code without spaces in second box. **Processing:** ACS will populate the billing provider taxonomy based on the NPI number given in box 56 per the NPPES database.

7.4 ADA Dental

Box 3	Primary payer information
Box 4-11	Other coverage – leave blank if no other coverage
Box 15	**Required** Policyholder/Subscriber ID (SSN or ID#) will be the full 12 digit claim number of the injured worker. (Note: the claim number can be listed anywhere on the form.) **Processing:** If claim number is missing or invalid, the bill will be forwarded to the Medical Auditor Box. MSF will modify the bill to indicate which claim to process the bill on or instruct to have the bill deleted and destroyed.
Box 17	Employer Name
Box 20	**Required** Name and address of injured employee – accept bill if information in Box 12.
Box 21	**Required** Injured employee date of birth – accept bill if information is in Box 13.
Box 22	**Required** Injured employee gender – accept bill if information is in Box 14.
Box 24	**Required** Procedure date of service
Box 27	**Required** Tooth number – (if applicable) enter tooth number or range of teeth using a hyphen, if applicable
Box 28	Designate tooth surface(s), if applicable
Box 29	**Required** Procedure code – enter the appropriate dental code
Box 30	**Required** Description of procedure
Box 31	**Required** Fee – enter corresponding fee for each procedure listed in column 29
Box 33	**Required** Total fees
Box 48	**Required** Billing entity name and address
Box 49	**Required** Billing provider NPI – input 10-character NPI number. **Processing** If the NPI is not supplied, the bill will be denied with reason code "Claim contains incomplete/missing other procedure and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information". Do not populate this field if not on form – instead leave blank. Billing provider Taxonomy – ACS will populate the billing provider taxonomy based on NPI number in box 49 per the NPPES database.
Box 51	**Required** Federal tax identification number
Box 53	**Required** Rendering dentist's signature
Box 54	Rendering dentist NPI – input 10-character NPI number. **Processing:** Enter if present. Do not populate this field if not on form – instead leave blank.
Box 56	**Required** Rendering dentist address, city and zip code
Box 57	Rendering dentist phone number (not required)

*The following bills will not have NPI numbers and shouldn't be denied for this reason or returned to MSF for correction:

- Vocational Rehabilitation
- Mortuary
- Health Club membership
- Schools/Retraining
- Supplies and DME from non-DME supply houses
- Industrial Hygiene
- Medical Case Management
- Independent Medical Evaluations billed by a panel MT PPO provider
- Ambulance
- Home/Vehicle Modification
- Procedure Codes H5300, ME100, M1000 and L3649
- Infusion Therapy Centers

Traveling Providers Exception for Box 32 and 32a:
For physicians who travel on behalf of MSF to provide IME's and Impairment Ratings where the space is leased or rented from a clinic or facility as an extension of their own office, and where the clinic or facility do not have billing/reporting responsibility (i.e., they will not be billing a facility fee) completion of Box 32 and 32a:

1. Box 32
    - Service Provider's Name
    - Clinic or Facility physical address
    - Clinic City, State and Zip Code

2. Box 32a
    - Provider's billing NPI

8 FEE SCHEDULE

Fee Schedule – The DOLI has adopted two fee schedules to be used in coordination with each other, the Montana Professional Fee Schedule (MPFS) and Montana Facility Fee Schedule (MFFS).

8.1 Montana Professional Fee Schedule (MPFS)

Montana Professional Fee Schedule (MPFS) - the allowed reimbursement paid to a professional provider for services and procedures provided in a non-facility or facility setting. These fees are based on a resource-based relative value scale (RBRVS) by which a relative value unit (RVU) is assigned to a specific service or procedure. The RVU is then multiplied by the Montana WC conversion factors to determine the Montana reimbursement amount to individual medical providers for non-facility medical procedures and services.

- **Conversion Factor (CF) —** The conversion factor represents the dollar value of each relative value unit. When this dollar amount is multiplied by the total relative value units (RVU) (facility or professional) assigned to a specific service or procedure, it will yield the allowed fee for that specific service or procedure.

Year	Standard	Year	Anesthesia
1/1/2008 - 12/31/2008	$63.45	1/31/2009 - 12/31/2009	$61.98
1/1/2009 - 6/30/2013	$65.28	1/1/2010 - 6/30/2013	$60.97
7/1/2013 -	$60.52	7/1/2013 -	$61.40

- **Professional and Facility Reimbursement Columns -** The MPFS reimburses at a professional and a facility rate.
    - **Professional Reimbursement** — the allowed fee paid for each service when that service is provided in professional settings, such as the physician's office, patient's home, or other non-facility setting.
    - **Facility Reimbursement —**the **medical provider's allowed fee** for each service when that service or procedure is provided in a hospital, ambulatory surgery center (ASC), skilled nursing facility (SNF), or other licensed medical facility setting.

  NOTE: Provider based clinics will be reimbursed only under the Professional Fee Schedule non-facility column. All professional provider claims are to be billed on a CMS 1500 form.

Refer to 2013 Professional Fee Schedule Instruction Set - http://mtwcfeeschedule.ingenix.com/feeSchedule.aspx.

MCA - 39-71-1101. Choice of health care provider by worker -- insurer designation of treating physician -- or managed care organization -- payment terms -- definition. (4) The treating physician designated by the insurer must be reimbursed at 110% of the department's fee schedule. (5) A health care provider to whom the worker is referred by the treating physician must be reimbursed at 90% of the department's fee schedule. (6) A health care provider providing health care on a compensable claim prior to the designation of the treating physician by the insurer must be reimbursed at 100% of the department's fee schedule.

- The role of primary care provider (PCP) is only assigned to claims with DOI 7/1/11 and forward. MSF is using this role to differentiate between a claim that will receive the tiered payments for services rendered. If a claim with a date of injury prior to 7/1/11 was enrolled in the MCO and had the provider designated by the MCO as the treating physician, the claim may also be assigned the role of primary care provider (PCP).
- PCP role cannot be assigned to an out-of-state provider because tiered payments only apply to MT Fee Schedule.
    - If the primary care provider (PCP) bills below the fee schedule, payment will be processed at 110% of the charge. Referred provider bills will be paid at 90% of the fee schedule or U&C.
    - NOTE: For services provided under a CAH tax id#:
        1) DOS through 6/30/13 process at U&C
        2) DOS on or after 7/1/13 will be processed under the same rules as all providers under the MPFS.
- If the designated or referred provider bills above the fee schedule, the bill will be reimbursed at 110% or 90% of fee schedule, regardless if payment is above billed amount.

8.2 Montana Facility Fee Schedule (MFFS)

Montana Facility Fee Schedule (MFFS) - The Montana Facility Fee Schedule is intended to guide the direct reimbursement for two specific types of Montana facilities, namely Acute Care Hospitals and Ambulatory Surgery Centers (ASCs), for WC services provided on and after 12/01/08.

- **DRG and APC reimbursement** – The MFFS reimburses with a MS-DRG System and an Outpatient (APC) Reimbursement System.
    - **MS-DRG System** – A payment system that classifies hospital **inpatient** cases into one of approximately 750 groups that are expected to have a similar hospital resource use. MS-DRGs in Montana are reimbursed at the same rate for all Acute Care Hospitals for WC medical services.
    - **Outpatient (APC) Reimbursement System** - The Montana WC system reimburses both Acute Care Hospitals and Ambulatory Surgery Centers (ASCs) for **outpatient** medical services using the Montana Facility Fee Schedule ‘s APC system.

Refer to Montana Facility Fee Schedule: Overview and Resources – http://erd.dli.mt.gov/workers-comp-claims-assistance/medical-regulations/montana-facility-fee-schedule.html and the Facility Fee Schedule Instruction Set for 2013 - http://erd.dli.mt.gov/images/stories/pdf/wc_studyprojects/fee_schedules/Facility%20Fee%20Schedule%20Instruction%20Set.pdf

9 UTILIZATION AND TREATMENT GUIDELINES

www.mtguidelines.com

The Montana Guidelines establish evidence-based utilization and treatment guidelines for primary and secondary medical services for workers' compensation injuries and occupational diseases, as authorized by § 39-71-704, MCA, and incorporated by reference in ARM 24.29.1591. The Guidelines include General Guideline Principles at the beginning of each chapter, which are designed to adequately and consistently address the functional improvement goals of an injured worker.

The Guidelines are applicable to all medical services provided on or after July 1, 2011. (The Guidelines establish a presumption of compensability for injuries and occupational diseases occurring on or after July 1, 2007. For those occurring on or before June 30, 2007, treatment in accordance with the guidelines constitutes reasonable primary or secondary medical treatment.)

Prior authorization is not required for treatment within the Guidelines. Prior authorization may be obtained in specific cases for treatments outside the guidelines as provided by ARM 24.29.1593. Disputes regarding treatment and prior authorization may be brought to the Department under the Independent Medical Review process in ARM 24.29.1595. Managed Care Organizations and Preferred Provider Organizations are required to follow the Guidelines, but the Guidelines do not alter their payment agreements.

The purpose of the Guidelines is to assist injured workers in receiving prompt and appropriate care, assist injured workers in stay-at-work/return-to-work options, assist clinicians in making decisions for specific conditions, and help insurers make reimbursement determinations. Although the primary purpose of the guidelines is advisory and educational, the guidelines are enforceable for payment purposes. The department recognizes that acceptable medical practice may include deviations from these guidelines, as individual cases dictate. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care.

Note: U & T Guidelines will be used as a guide to determine payment/denial on bills. Codes listed in the following sections of this manual don't necessarily constitute acceptance or denial of specific CPT codes but is noted for clarification purposes. (For example – The physical/occupational therapy section lists "Infrared light therapy – CPT 97026" which may or may not be an accepted treatment based on the U & T guidelines).

10 DISALLOWED PROCEDURES

For investigational or not medically necessary services, please refer to U & T guidelines and the ARM 24.29.1526.

11 SCOPE OF PRACTICE

Providers must bill services that fall within their scope of practice. Refer to ARM Rule 24 Labor and Industry and MCA Title 37 Professions and Occupations. Any services performed outside the defined scope of practice need to be denied as "Procedure not in provider's scope of practice."

12 EVALUATION AND MANAGEMENT AND OTHER SERVICES

MSF utilizes all Evaluation and Management (E&M) codes listed in the Current Procedural Terminology (CPT) manual and the coding conventions and guidelines therein.

Services provided by an independent practitioner in a hospital, ASC, SNF or other licensed medical facility setting are reimbursed to the individual provider using the **facility column** of the MT Professional Fee Schedule.

Bills received without medical records should be denied as "Procedure insufficiently identified or quantified."

24.29.1533 NONFACILITY FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 - 6/30/13 Where a procedure is not covered by these rules, the insurer must pay a reasonable fee, not to exceed the usual and customary fee charged by the provider to non-workers' compensation patients unless the procedure is not allowed by these rules.

7/1/13 Where a procedure is not covered by these rules or uses a new code, services will be reimbursed at 75% of the provider's U & C.

MT001

- This code is Montana specific and **replaces code 97799** for al1 medical providers for dates of service on or after 1/1/08. It is to be used for the following services:
    - face to face conferences with payer representative(s) to update the status of a patient upon request of the payer;
    - a report associated with non-physician conferences required by the payer; or
    - completion of a job description or job analysis requested by the payer.
    - Written questions that require a written response from the provider, excluding the Medical Status Form.
- An RVU of 0.5 per 15 minutes of service has been created for this code. Time needs to be documented in the notes as with any codes where time is a factor.
- If a provider bills with code 97799 for these services, deny as "Not a valid PT or OT code for Montana."

99050, 99051, 99053, 99056, 99058 and 99060

- Codes 99050, 99051, 99053, 99056, 99058 and 99060 are for out of ordinary service circumstances and must be billed in addition to the basic service. The reason must be clearly documented in addition to the time of day, etc. to substantiate these codes.

99070 – Supplies and Materials

- **For dates of service on or after 1/1/08** - When supplies are provided in an office setting, the most appropriate HCPCS code must be billed. When no such code exists, 99070 may be used. For charges billed less than $30.00 where there is no fee schedule listed, reimbursement will be at the billed amount. Reimbursement for supplies that are billed for $30.00 or more will be limited to $30.00 or 30% above the cost of the item, including freight. An invoice must be attached to the billing. Reference ARM 24.29.1522.

99080 – Special Report

- Special reports for more than the information conveyed in the usual medical communications or standard reporting form. A separate report must be submitted.
- Will reimburse 100% of billed amount as is a By Report (BR) code. When billed with an E & M code it is allowed only under the following circumstances:
    - The charge is for a letter that the physician wrote to the adjustor, MCO, or rehab vendor (make sure the letter is not simply the office note for that date of service copied onto letterhead paper); or
    - The charge is for reviewing job analysis (valid through 12/31/07). Effective 1/1/08 providers must bill with MT001.
    - Questions brought by the Claim Examiner over and above that which would be provided in conjunction with the regular E&M code billed (through 6/30/13 only, then they must use MT001).
- 99080 should NOT be used to bill for:
    - An impairment rating (99455-99456);
    - An Independent Medical Examination (IME);
    - Any office visit or consultation (99201-99275);
    - A charge for copying office notes for that date of service (L9084); or
    - Job Analysis
- If no separate report is submitted, deny as "Procedure insufficiently identified or quantified." Cannot be billed with 99455 or 99456.

99082 – Unusual Travel

- Review medical records for site of visit and reason for the travel.

99199 - Unlisted Special Service or Report (also known as "dump codes")

- Will reimburse 100% of billed amount as this code is a By Report (BR) code.
- 99199 billed with an E&M code is allowed only under the following circumstances:
    - A letter from a physician to the Claim Examiner, MCO, or rehabilitation vendor (not simply the office note for that date of service copied onto letterhead); or
    - Questions brought by the Claim Examiner over and above that which would be provided in conjunction with the regular E&M code billed through dos 6/30/13 then providers must use MT001.
- 99199 should **NOT** be used to bill for or with:
    - An impairment rating (99455-99456);
    - An Independent Medical Examination (IME) for contracted venders;
    - Any office visit or consultation (99201-99275); or
    - A charge for copying office notes for that date of service.
    - Review of job analysis(s) for dates of service prior to 1/1/08.

99241-99245 – Consultation Evaluation and Management

- MSF will continue to follow CPT guidelines and recognize consultation codes.

99354-99359 - Prolonged Services

- Time spent must be clearly documented.
- 99358 can be billed as a stand-alone code with 99359 for additional time (effective 1/1/2010) and must summarize records reviewed.

99455-99456 – Impairment Rating

- For dates of service from 1/1/08 through 6/30/13, DOLI established the following RBRVS values for 99455 & 99456::
    - 99455 2.5 RVU / 99456 2.8 RVU
- For dates of service on or after 7/1/13, 99455 and 99456 will be paid at U&C as there are no values associated with these codes.

13 General Medicine

13.1 Psychiatry

90801-90899

- All timed codes must have the time documented in the office notes submitted for each code billed for reimbursement. If time is not documented, deny as "Timed procedure - Submit treatment time."

14 AMBULANCE

Billing

- Usually billed with HCPCS codes A0021 – A0999. Only SI "A" codes may be reimbursed.
- Documentation such as the ambulance trip ticket is required for reimbursement. If no documentation is submitted, deny the bill as "Procedure insufficiently identified or quantified

Reimbursement

- Payments are made in accordance with the MT Ambulance Fee Schedule. These rates are effective 12/1/2008 and are subject to change annually per Department of Labor and Industry.
- The Montana Ambulance Fee Schedule (MAFS) is based on data in the CMS "2008 Ambulance Fee Schedule PUF Final," but contains only Workers' Compensation (WC) reimbursement rates and calculations for Montana. The MAFS includes both ground and air ambulance services.

Mileage

Note: Where the injured worker is when he/she needs to be transported is the deciding factor regarding whether you calculate mileage by the urban base rate or the rural base rate.

Ground Mileage, per WC mile: $12.45 (12/1/08 – 6/30/13)			
A0425	Urban Base Rate $9.95	Rural Base Rate $9.95	Multiply # of miles by WC mile & add appropriate base rate. Ex: 442 miles X $12.45 = $5,502.90 + base rate $9.95 = $5,512.85 (Urban and rural calculations are the same d/t same base rates).
Fixed Wing Air Mileage, per WC mile: $17.89			
A0435	Urban Base Rate $11.92	Rural Base Rate $17.89	Multiply # of air miles by WC mile & add appropriate base rate. Urban Ex: IE was transported from Missoula to Seattle 393 miles x $11.92 = $4,684.56 + base rate $17.89 = $4,702.45 Rural Ex: IE was transported from Helena to Seattle 487 miles x $17.89 = $8,712.43 + base rate $17.89 = $8,730.32
Rotary Wing Air Mileage, per WC mile: $47.66			
A0436	Urban Base Rate $31.78	Rural Base Rate $47.66	Multiply # of air miles by WC mile & add appropriate base rate. Urban Ex: IE was transported from Missoula to Seattle 393 miles x $31.78 = $18,730.38 + base rate $31.78 = $18,7623.16 Rural Ex: IE was transported from Helena to Seattle 487 miles x $47.66 = $23,210.42 + base rate $47.66 = $23,258.08

Life Support Services

These are additional services provided in conjunction with the transport of an IE. There are 2 base rates for these services: Urban and Rural. The amounts listed for each code is added to the total mileage sum for the total reimbursement for ambulance services in addition to any other SI "A" codes that may also be billed using the Facility Fee Schedule or 75% of U&C if there is no fee schedule listed.

For Dates of Service 12/1/08 – 6/30/13:

HCPCS	Urban Base Rate	Rural Base Rate	Explanation of Service Mode
A0426	$339.61	339.61	Ambulance service, advanced life support, non-emergency transport, level 1(ALS).
A0427	$537.70	$537.70	Ambulance service, advanced life support, emergency transport level 1.
A0428	$283.00	$283.00	Ambulance Service, basic life support, non-emergency transport (BLS).
A0429	$452.80	$452.80	Ambulance service, basic life support, emergency transport (BLS-Emergency).
A0430	$3,876.58	$5,814.86	Ambulance service, conventional air services, transport, one way (fixed wing).
A0431	$4,507.07	$6,760.62	Ambulance service, conventional air services, transport, one way (rotary wing).
A0432	$495.24	$495.24	Paramedic intercept (PI), rural area, transport furnished by a volunteer.
A0433	$778.24	$778.24	Advanced life support, Level 2 (ALS 2)
A0434	$919.74	$919.74	Specialty care transport (SCT)

For dates of service on or after 7/1/13:

Local	HCPCS	Base Rate	RVU	GPCI	Urban Base Rate / Urban Mileage	Rural Base Rate / Rural Mileage	Rural Base Rate / Lowest Quartile	Rural Ground Miles 1-17*
1	A0425	6.95	1	n/a	$7.09	$7.16	n/a	$10.74
1	A0426	216.19	1.2	1	$264.62	$267.21	$327.60	n/a
1	A0427	216.19	1.9	1	$418.98	$423.08	$518.70	n/a
1	A0428	216.19	1	1	$220.51	$222.68	$273.00	n/a
1	A0429	216.19	1.6	1	$352.82	$356.28	$436.80	n/a
1	A0430	2933.78	1	1	$2,933.78	$4,400.67	n/a	$4,400.67
1	A0431	3410.96	1	1	$3,410.96	$5,116.44	n/a	$5,116.44
1	A0432	216.19	1.75	1	$385.90	$389.68	n/a	n/a
1	A0433	216.19	2.75	1	$606.41	$612.36	$750.75	n/a

Local	HCPCS	Base Rate	RVU	GPCI	Urban Base Rate / Urban Mileage	Rural Base Rate / Rural Mileage	Rural Base Rate / Lowest Quartile	Rural Ground Miles 1-17*
1	A0434	216.19	3.25	1	$716.67	$723.70	$887.25	n/a
1	A0435	8.32	1	n/a	$8.32	$12.48	n/a	$12.48
1	A0436	22.21	1	n/a	$22.21	$33.32	n/a	$33.32

Note: Air Carrier services are preempted under the federal Airline Deregulation Act of 1978 (ADA) (49 USC 41713(b) which states "a state, political subdivision of a state, or political authority of at least two states may not enact or enforce a law, regulation or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.". The State of Montana does not have the authority to set a fee schedule rate on worker's compensation injured workers that are transported via air carrier under this law. An air carrier company may request a reconsideration based upon this law, in that event, the bill will need to be re-evaluated to pay the remainder of the usual and customary fee that was charged.

15 SURGERY

Any procedure code that starts with a 1, 2, 3, 4, 5, or 6 is a surgery code.

Acute vs. Chronic Guidelines

Per AAPC Guidelines, generally accepted interpretation of acute vs. chronic is as follows:

- Acute – less than six months.
- Chronic – over 6 months.

However, for codes where etiology is used to determine whether the code billed is correct, (i.e.: 23410 and 23412), the following guideline is:

- Acute - Traumatic injury (i.e.: acute rotator cuff tear-a fall on an outstretched hand or football throwing)
- Chronic – Overuse or chronic stress.

Reimbursement

Services provided by an independent practitioner in a hospital, ASC, SNF or other licensed medical facility setting are reimbursed to the individual provider using the **facility column** of the MT Professional Fee Schedule. Dates of service through 6/30/13 services provided by an employee of the facility are reimbursed to the facility using the MT Facility Fee Schedule. Dates of service on or after 7/1/13, services must be billed on a CMS 1500 form and reimbursed per MPFS.

Burn and Laceration Repairs

- ACS can process bills with burn and laceration repairs with no length documented in the medical record as long as the billing entity is billing the CPT code with the smallest repair size. Billing other than the smallest repair size must be documented.

Multiple Surgery/Procedure Guidelines

- MSF utilizes multiple surgery/procedure practices when reimbursing surgical services.
- When multiple procedures, other than E&M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 or 59 to the additional procedure or service code(s).
- The procedure with the highest fee schedule value (primary) should be paid at full fee schedule.
- For dates of service through 6/30/13, each additional procedure will be paid at 50% of fee schedule where multiple procedure guidelines apply.
- For dates of service on and after 7/1/13 reduction will be as follows:

First subsequent procedure	75% of fee schedule
Second subsequent procedure	50% of fee schedule
Third and all additional subsequent procedures	25% of fee schedule

See Modifiers in this section.

- Note: Modifier 51 should not be appended to designated "add-on" codes (these are located in Appendix D and are noted with a + in front of them in the CPT manual). In addition, some codes are exempt from multiple procedure guidelines and are identified by the ⃠ symbol in the CPT manual. See the CPT manual, Introduction, Modifiers section for more information.

Assistant Surgeon Guidelines

- Assistant surgeon services must be billed separately. The primary surgeon documentation is sufficient for assistant surgeon bills as long as the assistant surgeon's name is listed on the surgeon's record. If the primary surgeon bills the assistant's services, deny the bill as "Denied per Carrier decision" and "Incorrect use of modifier."
- Assistant Surgeon services must be appended with the applicable modifier (80, 81 or 82). If the bill contains the AS modifier, ACS will crosswalk the modifier to the 80, 81, or 82 modifier and process the bill accordingly. See Modifiers in this section. **NOTE**: Only licensed providers practicing within the scope of their licensure may bill assistant surgeon charges: Physician Assistants, Nurse Practitioners, and Advanced Practice Nurses. See letter to Montana Medical Association.
- Non-licensed personnel services will not be reimbursed for assistant surgeon services. Deny bill as "Denied per Insurance Carrier decision" and add "non-licensed surgical assist does not warrant a fee". See letter to Montana Medical Association.

Global Surgical Package

- The payment for a surgical procedure includes a standard package of preoperative, intra-operative, and postoperative services as outlined by CPT Guidelines. The preoperative period included in the global fee for surgery is 1 day. The postoperative period for major surgery is 90 days. The postoperative period for minor surgery is either 0 or 10 days depending on the procedure. For endoscopic procedures (except procedures requiring incision), there is no postoperative period.
- The approved amount for these procedures includes payment for the following services, as outlined by CPT guidelines, related to the surgery when furnished by the physician who performs the surgery.
    - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
    - Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
    - Immediate postoperative care, including dictating operative notes, talking with family and other physicians;
    - Writing orders;

- Evaluating the patient in the post-anesthesia recovery area; and
- Typical postoperative follow-up care. This includes postoperative E/M codes billed within the global surgery period.
- **Note:** Radiology services are not considered to be part of the global surgery package.

- E&M codes billed within the postoperative global surgery period appended with –24 modifier are payable. Modifier 24 states "Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period". The documentation will need to be reviewed to confirm that the service is unrelated and not covered under the global surgical package. If the services appear related to the surgical procedure and falls into the global period, deny the bill as "Included in global fee of surgical procedures".

Most Common and Costly Surgery Bill Mistakes

- Surgery codes billed without modifier –51. If a multiple procedure bill is processed without the modifier-51, it causes an overpayment as the payment should be 50% of fee schedule. Multiple procedure will be utilized on all multiple procedure bills regardless as to whether the 51and/or the 59 modifier is present on the bill.
- Incorrect number of units entered with modifier –50 and –51. Modifier –50 is programmed to pay 150% so you only need to enter one unit. Modifier –51 is programmed to pay 50% so you need to enter one unit on the primary procedure without the –51 modifier.
- Assistant surgeon bills. Make sure the surgical assistant bills with the same codes as the primary surgeon. If the codes are not the same, forward the bill to the Medical Auditors box for review.
- Do **not** pay code 96372 (therapeutic or diagnostic injection) when billed with a surgical type of injection code(s) such as 20550-20610. The administration of the injection *is included* with the surgical injection code. Deny code 96372 as "CCI-bundled in another billed procedure" which indicates to the provider that code 96372 is included in the other code.
- The provider can bill the appropriate J code for medication. J codes **can** be submitted in conjunction with code range 20550-20610.

15.1 Modifiers

The complete list of code modifiers can be found in both the Current Procedural Terminology (CPT) and the Montana Professional Fee Schedule Instruction Set. The following modifiers *change the fee schedule amount that is paid.*

-22 Unusual Procedural Services

- **For dates of service on or after 1/1/08 -** when the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number.

-50 Bilateral Procedures

- Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier –50 to the appropriate five-digit code. Enter the procedure code once with the –50 modifier with 1 unit. The system will pay 150% of the fee schedule for that procedure (one side at the full allowable amount and the other side at half the fee schedule amount). Add-on codes are exempt from the –50 modifier as the charges cannot be reduced from the fee schedule rate. ***Multiple surgery rules apply.***

-51 Multiple Procedures

- Multiple procedures are procedures other than E&M that are performed at the same session by the same provider. These include secondary, tertiary, and incidental procedures. Multiple procedures should be listed according to value. The primary procedure should reflect the greatest fee schedule value and should not include the -51 modifier. All other procedures should be listed in decreasing value using modifier -51. The primary procedure will be reimbursed at 100% of fee schedule in effect at the time of the service. For dates of service through 6/30/13 the secondary and each additional procedure will be reimbursed at 50% of the fee schedule in effect at the time of the service. For dates of service on or after 7/1/13 the first subsequent procedure will be reimbursed at 75% of the fee schedule; the second subsequent procedure will be reimbursed at 50% of fee schedule and the third and all additional subsequent procedures will be reimbursed at 25% of fee schedule.
- NOTE: This modifier should not be appended to designated "add-on" code(s) or code(s) exempt from modifier -51.
- Reason code "Modifier 51-Multiple procedures performed" must be data entered for each line item that is appended with modifier –51 to explain to the provider that a modifier has been added to the procedure code because multiple procedures were performed.

-54 Surgical Care Only

- When one physician performs the surgical care and another physician provides the preoperative/postoperative management, the surgical services may be billed by adding the -54 modifier to the procedure code. Multiple procedure rules apply.

-55 Postoperative Management Only

- When one physician performs the postoperative management and another performs the surgical component, the postoperative component may be billed using the -55 modifier. Multiple procedure rules apply.

-56 Preoperative Management Only

- When one physician performs the preoperative management and another performs the surgical component, the preoperative component may be billed using the -56 modifier. Multiple procedure rules apply.

-59 Distinct Procedural Services

- Under certain circumstances, the physician may need to ***indicate that a procedure or service was distinct or independent from other services performed on the same day***. Modifier –59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.
- ***HOWEVER, WHEN ANOTHER ALREADY ESTABLISHED MODIFIER IS APPROPRIATE, IT SHOULD BE USED RATHER THAN THE –59.*** Only if no more descriptive modifier is available, and the use of modifier –59 best explains the circumstances, should modifier –59 be used. Modifier –59 has been approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use.
- If the circumstance warrants the use of a second modifier in conjunction with –59, the level of payment is determined by the guideline for the second modifier.

-62 Two Surgeons

- When two surgeons work together as **primary surgeons** performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier –62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as **primary surgeons**. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including any add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with the modifier –62 added. NOTE: ***If a co-surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, those services(s) may be reported using a separate procedure code(s) with modifier –80 or modifier –82 added, as appropriate.***
- Two Surgeons: Under certain circumstances, the skills of two surgeons ***(usually** with different skills)* may be required in the management of a specific surgical problem (e.g., an urologist and a general surgeon in the creation of an ileal conduit, etc.)
- The procedure should be valued at the customary value of 125% of the value listed. The total value (125%) may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the arrangement. Divide the 125% customary value by two and allow one-half to each surgeon. ***Multiple surgery rules apply***
- For dates of service on or after 7/1/13, ***only multiple surgery rules apply.***

-66 Surgical Team

- Under some circumstances, a highly complex procedure(s) (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier –66 to the basic procedure number used for reporting services.

-77 Repeat Procedure by Another Physician

- It may be necessary for a physician to perform a procedure or service again that was initially performed by another physician. When documented properly, the payment is 125% of the allowed fee.

-78 During the Post Op period, a return to the operating room for a related procedure

- When a related procedure is performed during the post operative period of the initial procedure and was performed in an operating room, the payment is 70% of the allowed fee.

-80 Assistant Surgeon

- Surgical assistant services (physician only) may be identified by adding modifier –80 to the usual procedure number(s). This modifier warrants 20% of the fee schedule.
- When a qualified physician provides surgical assistance, the use of modifier –80 is appropriate. An MD receives 20% of the fee schedule amount. PA, NP and APRN use modifier 81. ***Multiple procedure rules apply.***
- If the primary surgeon bills the assistant's services, deny the bill as "Denied per Carrier decision" and "Incorrect use of modifier."

-81 Minimum Assistant Surgeon

- **PA, NP, APRN should be reimbursed following the –81 modifier guidelines. It is appropriate for MD's to bill with this modifier also.**
- **For dates of service 1/1/08 and forward -** minimum surgical assistant services are identified by adding modifier -81 to the procedure code. This modifier will be reimbursed at 15% of the fee schedule.
- If the primary surgeon bills the assistant's services, deny the bill as "Denied per Carrier decision" and "Incorrect use of modifier."

-82 Assistant Surgeon – (when a qualified resident surgeon is not available)

- This modifier applies to teaching hospitals that have residency programs (none in Montana). If a different modifier is appended, reason code "Incorrect use of modifier" should be used. ***The unavailability of a qualified resident surgeon is a prerequisite for use of modifier –82 appended to the usual procedure code number(s) and it must be documented that a qualified resident was not available.***
- When a qualified resident surgeon is unavailable and a qualified non-resident surgeon provides surgical assistance, the use of modifier –82 is appropriate. An MD receives 20% of fee schedule. ***Multiple surgery rules apply.***
- If the primary surgeon bills the assistant's services, deny the bill as "Denied per Carrier decision" and "Incorrect use of modifier."

16 Facilities

Effective Dates

- **For dates of service 12/1/2008 and forward *– refer to the MS-DRG -*** Inpatient Hospital section or the APC – Outpatient Hospital or Ambulatory Surgery Center section of this manual.
    - Follow the guidelines established in the Administrative Rules of Montana (ARM) in rule 24.29.1406.
        - Inpatient hospital stays (determined by discharge date)
        - Outpatient hospital
        - Surgery Centers

For dates of service on or after 7/1/13 see the Facility Instruction Set for 2013 at http://erd.dli.mt.gov/images/stories/pdf/wc_studyprojects/fee_schedules/Facility%20Fee%20Schedule%20Instruction%20Set.pdf

The Fee Schedule is based on MS-DRG's and APC's utilizing Medicare's current weights but the Department of Labor and Industry's (DOLI) adopted base rates for Montana**.**

Montana Code Annotated (MCA) rule 50-5-101 (23)(a) and (23)(b) definition of facility: "Health Care Facility" or "Facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, long-term care facilities, intermediate care facilities, for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

The term does not include outpatient centers for primary care, infirmaries, provider based clinics, offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors."

The following services will be reimbursed by the Montana Facility Fee Schedule (MFFS):

- Hospital
- Ambulatory Surgery Center
- Ambulance

Audits will be completed on inpatient, outpatient, and ASC's post payment.

Records will not be required to be submitted with bills with the exception of outpatient services such as emergency room, therapies, labs, or radiology reports, during a post-payment audit or when records are not available from another source.

16.1 MS-DRG - Inpatient Hospital

Medicare-severity diagnosis related group (MS-DRG) is the inpatient diagnosis classifications of circumstances where patients demonstrate similar resource consumption, length of stay patterns, and medical severity status.

Reimbursement

In order to calculate reimbursement for a hospital stay, the services will need to be "grouped" using a module which takes five elements and assigns a numerical "grouper" with a weighted value. The five elements are:

- ICD-9 procedure codes
- ICD-9 diagnoses
- Gender
- Age
- Discharge status

The weighted value is calculated by the base rate adopted by DOLI x MT MS-DRG weight determined by the elements above. Note: If the provider bills less than the fee schedule, insurer pays fee schedule.

- Base rates:
    - 12/1/08 - 6/30/13: $7,735.00
    - On or after 7/1/13: $7,944.00

Outlier Payments

There are two "outlier" circumstances that will result in an additional payment:

- **Outlier threshold** - When hospital billed charge is 3x the Montana MS-DRG set by DOLI.
    - If outlier threshold (MS-DRG x3) is met, the total payment is determined by adding the MS-DRG + the outlier payment. The outlier payment is determined by multiplying the charges above the threshold [Billed Charges – (DRG Pmt x3)] by the sum of the hospital's MT operating ratio of cost to charges (RCC) and .15 (RCC +.15).
    - **MS-DRG + [[Billed Charges – (DRG Pmt x3)] x (RCC +.15)] = Total Pymt**
        - Example: MS-DRG = $25,000, Billed Charges = $100,000, RCC = 0.50. $25,000 + [[$100,000 – ($25,000 x3)] x (0.50 + .15)] = $41,250.00
    - **Note**: Additional payments for implants >10K are excluded from outlier calculations, i.e. implant charges are subtracted from the bill for purposes of calculating the outlier threshold.

The Montana RCC (12/1/08 – 6/30/13)		
Hospital Name	CMS Provider Number	CMS 2008 Calculation of Individual Facility Cost to Charge Ratios.
Benefis Healthcare	270012	0.416
Bozeman Deaconess Health Services	270057	0.533
Central Montana Medical Center	270011	0.566
Community Medical Center	270023	0.522
Billings Clinic	270004	0.371
Healthcenter Northwest	270087	0.838
Holy Rosary Health Center	270002	0.416
Kalispell Regional Medical Center	270051	0.443
Northern Montana Hospital	270032	0.418
St James Community Hospital	270017	0.454
St Patrick Hospital	270014	0.377
St Peter's Hospital	270003	0.427
St Vincent Health Care	270049	0.377
This table lists the fourteen regulated (acute care and long-term care) hospitals in Montana and their RCC's (Ratio of Costs to Charges) in 2008. These RCC's are based on research and analysis conducted by the Centers for Medicare and Medicaid Services (CMS), utilizing financial reports submitted by each of the hospitals. When claim outliers are calculated, the individual hospital's RCC will be used as the basis in calculations. Reimbursement rates in this Fee Schedule remain unchanged until the next revision of this fee schedule referenced in the ARM.		

The Montana RCC (7/1/13)		
Hospital Name	CMS Provider Number	CMS 2008 Calculation of Individual Facility Cost to Charge Ratios.
Benefis Healthcare	270012	0.394
Billings Clinic Hospital	27004	0.347
Bozeman Deaconess Health Services	270057	0.424
Community Medical Center Inc	270023	0.457
Great Falls Clinic Medical Center	270086	0.449
Healthcenter Northwest	270087	0.718
Kalispell Regional Medical Center	270051	0.367
Northern Montana Hospital	270032	0.422
PHS Indian Hospital at Browning-Blackfeet	270074	0.388
St James Community Hospital	270017	0.438
St Patrick Hospital	270014	0.369
St Peter's Hospital	270003	0.474
St Vincent Health Care	270049	0.384

- **Implants** – When an implant cost exceeds the threshold set by DOLI (>$10,000), reimbursement is set at the actual amount paid for the implantable + 15%. An invoice must be submitted documenting the cost of the implant and should include the handling and freight charges. The implantable charge is excluded from the regular calculation for an outlier payment.
    - An implant is defined by DOLI as an object or device that is made to replace and act as a missing biological structure that is surgically implanted, embedded, inserted or otherwise applied. The term also includes any related equipment necessary to operate, program and recharge the implantable.
    - Note: Flowseal, drill bits, needles, probes, tools, etc are not reimbursed under the implant outlier.

16.2 APC – Outpatient Hospital or Ambulatory Surgery Center

Ambulatory Payment Classification (APC) is the reimbursement system adopted by DOLI for outpatient services provided in either a hospital or an ambulatory surgery center. Refer to the DOLI website - http://erd.dli.mt.gov/workers-comp-claims-assistance/medical-regulations/montana-facility-fee-schedule.html

Billing

Outpatient hospital and Ambulatory Surgery Center (ASC**)** services should be billed on a UB04 using revenue codes, if applicable, with corresponding CPT codes.

Reimbursement

CPT/HCPCS - Each CPT code is paid per the corresponding APC weight X the base rate. Note: If the provider bills less than the fee schedule, insurer pays fee schedule.

- APC Weight – Listed on the DOLI website.
- Base Rate - there are two base rates:
  - Outpatient Hospital
    - 12/1/08 - 6/30/13: $105
    - On or after 7/1/13: $107
  - Ambulatory Surgery Center
    - 12/1/08 - 6/30/2013: $79
    - On or after 7/1/13: $80
- If the APC weight is not listed or if the APC weight is listed as null, reimbursement for that service must be paid at 75 percent of the facility's usual and customary charges. Examples of such services include but are not limited to laboratory tests, radiology, and therapies.

Status Indicators – Each APC, CPT and HCPCS code has been assigned a letter that signifies whether the MFFS will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. Only Montana SI codes can be used to calculate reimbursements for services and supplies. See the applicable table based on date of service to determine how to apply payment. SI's are paid at the fee scheduled amount listed, regardless of what the provider bills.

- If a service falls outside of the scope of the APC and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

Status Indicators through 6/30/13	
A	Fee Schedules – Ambulance If the item billed is a "non-ambulance" or "non-transportation" service, and a value is provided in the Montana fee schedule, that amount is appropriate to pay. If there is no value in the fee schedule, pay at 75% of the providers usual and customary" charge.
B	Non-Allowed item or service. Not a hospital service**.**
C	Inpatient procedures – not adopted, these should not be paid as an APC.
D	Discontinued service**.**
F	Acquisition costs paid for corneal tissue acquisition, certain CRNA services and Hepatitis B vaccines**.**
G	Additional payment for drug/biological pass-through
H	Additional payment for pass-through device categories, brachytherapy sources and

	radiopharmaceutical agents
K	Additional payment for non-pass-through drugs/biologicals
L	Flu and other vaccines
N	No additional payment, payment included in line items with APC's for incidental service
P	Paid partial hospitalization per diem payment
S	Significant procedure, not subject to multiple procedure discounting
T	Significant procedure, subject to 50% discount on second procedure if present
V	Clinic or emergency department visit – not adopted, payable at fee schedule or 75% if no fee schedule
X	Ancillary service

Status Indicators on or after 7/1/13	
A	Pay under professional or other schedule
B	Pay under professional or other schedule
C	If no value posted, Pay at 75% of UC
D	If no value posted, Pat at 75% of UC
E	Pay under professional or other schedule
F	If no value posted, Pay at 75% of UC
G	If no value posted, Pay at 75% of UC
H	If no value posted, Pay at 75% of UC
K	If no value posted, Pay at 75% of UC
L	Pay under professional or other schedule
M	Pay under professional or other schedule
N	Bundled Code, No separate Payment
P	Any length of stay under 24 hours for patient observation is considered outpatient. If there is no value, pay at 75% of UC
Q1	Pay per fee schedule, no multiple procedure discount
Q2	Pay per fee schedule, no multiple procedure discount
Q3	Pay per fee schedule, no multiple procedure discount
R	If no value posted, Pay at 75% of UC
S	Significant Separate Procedure
T	Multiple procedure discount applies
U	If no value posted, Pay at 75% of UC
V	If no value posted, Pay at 75% of UC
X	If no value posted, Pay at 75% of UC
Y	Pay under professional or other schedule

Example: A surgery center bills CPT codes 62311 for $1080 and 77003 for $180 UB04 form. Code 62311 corresponds with APC 0207, SI "T" and a weight of 7.0546. Therefore, 7.0546 X $79 (base rate for ASC) = $557.31. T SI does not change the payment in this case. Code 77003 has a SI of "N" (no additional payment) so the final payment is $557.31.

Outlier Payment

- **Implants** – When an implant cost exceeds the threshold set by DOLI, reimbursement is set at the actual amount paid for the implantable + 15%. An invoice must be submitted documenting the cost of the implant and should include the handling and freight charges. The outlier threshold for outpatient hospital and ASC's is $500 in cost.
    - Per ARM 24.29.1432 – "Where an outpatient implantable exceeds $500 in cost, hospitals or ASCs may seek additional reimbursement beyond the normal APC

payment. In such an instance, the provider may bill CPT code L8699, and the status indicator code "N" may not be used by a payer to determine the amount of payment. Any implantable that costs less than $500 is bundled in the APC payment".
    - For dates of service through 6/30/13 provider may bill CPT code L8699 or other applicable implant code for implant reimbursement.
    - For dates of service on or after 7/1/13, a provider must bill MT003 for implant reimbursement.
  - Note: Flowseal, drill bits, needles, probes, tools, etc are not reimbursed under the implant outlier.

16.3 Other Facilities

- **Critical Access Facilities and Medical Assistance Facilities**
- Reimbursed at 100% of usual and customary (U&C) charges.

- **Licensed Outpatient Center for Primary Care**
  Reimbursed at 75% of charge. In MT there are 6 such facilities:
  - Sound Health Imaging – Butte, MT
  - Colstrip Medical Center – Colstrip, MT
  - Family Birth Center – Great Falls, MT
  - Sound Health Imaging, Inc – Helena, MT
  - The Birth Center, Missoula, MT

- **Long-Term Extended Care Facilities**
  Reimbursed at 75% of U&C.
  - Advanced Care Hospital of Montana – Billings, MT (effective Sept 08). Note: Prior to effective date, reimbursed at 100%.

- **All other facilities not explicitly addressed by the MFFS rule**
  Reimbursed at 75% of that facility's U&C. Examples include,
  - Inpatient Rehabilitation Services
  - Home Infusion Therapy
    - Codes A4216 & A4217 (included and not payable)
  - Skilled Nursing Facilities

- **Provider Based Clinics (through 6/30/13 ONLY)**
  "Provider Based Clinic" is a designation and certification by Medicare for a clinic associated with a hospital and operates under the same Medicare certification as the hospital. The "Provider Based Clinic" MUST be certified under Medicare – self attestation is not sufficient.
  - Under Montana Workers' Compensation medical fee schedules, "Provider Based Clinics" may bill both a facility bill and a non-facility bill for a service. The clinic services (professional) must be billed on a CMS 1500 with place of service code 22 (not 11).
  - The exception to this rule is Critical Access Hospitals (CAH) – they may bill professional fees on the UB04 or CMS 1500 and must be paid 100% of usual and customary. Montana Department of Public Health and Human Services (DPHHS) updates a list of those facilities that are certified as Provider Based Clinics.

Montana Providers Based Clinics per DPHHS are as follows:

City	Provider Based Clinic
Dillon	Barrett Hosp and Healthcare (CAH) Barrett Hospital Clinic
Billings	Billings Clinic (Billings Hospital) Billings Clinic Billings Clinic West End Billings Clinic Pace
Bozeman	Bozeman Deaconess Hospital Bozeman Deaconess Health Group
Anaconda	Community Hosp of Anaconda (CAH) Anaconda Internal Medicine Anaconda Pediatrics Pintler Family Practice
Kalispell	Healthcenter Northwest Spine & Pain Center
Miles City	Holy Rosary Healthcare (CAH) Holy Rosary healthcare Clinic
Kalispell	Kalispell Regional Medical Center Northwest MT Surgical Association Rocky Mountain Heart and Lung
Livingston	Livingston Healthcare (CAH) Livingston Healthcare/Park Clinic Livingston Memorial Hospital
Big Timber	Pioneer Medical Center (CAH) Pioneer Medical Center
Billings	St Vincent Healthcare Internal Medicine Associates Behavioral Health Associates Broadwater Walk In Clinic Center For Healthy Living Heights Family Practice Laurel Medical Center Medical Practices Division Neuroscience Center Northern Rockies Regional PA Pediatric Specialty Care Services Physical Medicine Clinic Sleep Center Weight Management Clinic-B West Grand Family Medicine
Butte	St James Healthcare
Polson	St Joseph Hospital

City	Provider Based Clinic
Helena	St Peter's Hospital Apex of St Peters Cancer Treatment Center Hospice of St Peters Medical Office Building St Peters Medical Group St Peters Pharmacy Broadway St Peters Urgent Care
Libby	St John's Lutheran Hospital
Ronan	St Luke Community Hospital St Luke Community Convenient Care St Luke Community Clinic PO St Luke Community Clinic RO St Luke Community Hospital SWI

16.4 Correct Coding Initiative (CCI) Code Edits

CCI Edits will be utilized for all medical bills.

CCI Edits are pairs of CPT or Healthcare Common Procedure Coding System (HCPCS) Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service. All claims are processed against the CCI tables.

The Column 1/Column 2 correct coding edit table
The Column 1/Column 2 correct coding edit table contains two types of code pair edits. One type contains a column 2 (component) code which is an integral part of the column 1 (comprehensive) code.

The Mutually Exclusive Code Pair Edit File
The other type, the Mutually Exclusive Code, contains code pairs that should not be reported together where one code is assigned as the column 1 code and the other code is assigned as the column 2 code. If two codes of code pair edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a CCI associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed.

These edits remain unchanged until the next revision of this fee schedule section referenced in the ARM.

In utilizing these correct code files, remember to first test the code using one CPT code first, and then reversing the order of the CPT codes the second time around.

Example: Code Ranges 90000-99999 (Medicine Evaluation and Management Services)

Column 1	Column 2	Modifier
		0 = Not Allowed
		1 = Allowed
		9 = Not Applicable
90465	90467	0
90465	90471	0
90465	90473	0
90467	90471	0
90467	90473	0
90471	90473	0
90691	90690	0
90692	90690	0
90693	90690	0
90721	90645	1
90721	90646	1

17 IQAnalysis

Effective Dates

- **Dates of service 12/9/11 and forward -** Based on the criteria defined by MSF, ND and Mayo Clinic bills will be routed to IQAnalysis. **Out of State Provider** bills that meet the IQAnalysis criteria, with the exception of DME providers, will be routed to IQAnalysis for review.
    - All bills over $500.00 (billed charges) with no PPO reduction and less than 20% fee schedule reduction
    - Ambulance bills over $500.00 with no PPO and no fee schedule reduction
    - All Non physician bills (Inpatient, Outpatient, DME, and Ambulance) over $1.00 from AZ and UT with no PPO reduction
    - All Inpatient and Outpatient Hospital bills over $1.00 from CT, VA, and WI with no PPO reduction
    - All bills over $1.00 from IA, IN, MO, NH, and NJ with no PPO reduction

- IQ Analysis does not apply to services provided based on negotiations between MSF and the provider.

18 ANESTHESIA

Billing
Anesthesia must be submitted in a CMS 1500 form. The anesthesia record (not the operative report unless the service is for injections) must be submitted and must be legible. If billing for general anesthesia (Code range 00100 – 01999), a physical status modifier (P1 – P6) must be billed in addition to the required information on the CMS 1500 form. If the Physical Status modifier is missing, the bill will be denied as "Modifier missing."

Reimbursement
Anesthesia bills are processed according to the Resource Based Relative Value Scale (RBRVS) in conjunction with the conversion factor in effect at the time of the service. Anesthesia is paid using total time, even if billed with units. Total time must be documented on anesthesia record for payment consideration. If provider bills with units, total time will be used for payment calculation. The payment is calculated using the time that the patient was under anesthesia along with the base value of the anesthesia code. (Total time in minutes is divided by 15 (15 minutes = 1 unit) plus base units multiplied by conversion factor in effect at time of service). Do **NOT** round.

Conversion Rates
- 1/31/09 – 12/31/09: $61.98
- 1/1/10 – 6/30/13: $60.97
- 7/1/13 forward: $61.40

Services provided by an independent practitioner in a hospital, ASC, SNF or other licensed medical facility setting are reimbursed to the individual provider using the **facility column** of the MT Non-Facility Fee Schedule. For dates of service through 6/30/13 services provided by an employee of the facility are reimbursed to the facility using the MT Facility Fee Schedule. For dates of service on or after 7/1/13, services must be billed on a CMS 1500 and paid under the MPFS.

Multiple Anesthesiologists
- When there is more than one Anesthesiologist, the necessity should be substantiated by report (BR). The second anesthesiologist receives 5.0 base units plus time units (calculation of total anesthesia value). If documentation does not support the use of a second anesthesiologist, deny as" Procedure insufficiently identified or quantified."

Physical status modifiers
- Some patients, because of other physical conditions, require more monitoring by the physician. In these cases, physical status modifiers are added and add additional units to the pricing. See DLI MNFS Instruction Set. The choice of modifier MUST be substantiated in the submitted documentation. If no evidence can be found to support the use of the modifier, the line will be denied as "Procedure insufficiently identified or quantified." The Physical Status modifiers are:
    - P1 – a normal healthy patient
    - P2 – a patient with mild systemic disease
    - P3 – a patient with severe systemic disease (1 unit)
    - P4 – a patient with severe systemic disease that is a constant threat to life (2 units)
    - P5 – a moribund patient who is not expected to survive without the operation (3 units)

- P6 – a declared brain-dead patient whose organs are being removed for donor purposes.

- Per CPT guidelines a physical status modifier are required for codes 00100-01999.

99100-99140

- **For dates of service 1/1/08 and forward,** codes 99100-99140 have no RVU values attached to them in the RBRVS and will be paid at 100% of amount billed.

For dates of service 7/1/13 and forward, codes 99100-99140 are reimbursed as follows:

CPT	Unit Value
99100	1
99116	5
99135	5
99140	2

19 CHIROPRACTOR

Billing

- All timed codes must have time documented ***by code*** in the medical record. Time must be documented in minutes not units.
- Therapy codes billed must have part of body documented or it must be clearly identified in a flow sheet or other attached documentation.

Diagnostic x-ray

Documentation must support the services billed. If there is not an actual radiology report, the documentation in the notes must clearly identify the codes billed and the results. If no x-ray documentation is submitted, it will be denied as "Procedure insufficiently identified or quantified."

Do NOT pay for the following:

Deny as "Non-reimbursable service - Not billable to injured worker." These items are usually billed with code 99070.

- Supplements of any kind (vitamins, glucosamine, MSM, DMSO, etc.);
- Educational pamphlets and books; or
- Creams.

97799/MT001 and 99070, 99080

- Refer to Evaluation and Management Section.

Timed Modalities

Services of less than 8 minutes when that is the only service performed during a visit is not billable. Time intervals are incremented in 15 minute units (base is 8 minutes):

8-22 minutes =	1 unit
23-37 minutes =	2 units
38-52 minutes =	3 units etc

- When more than one service of a timed modality is performed in a single day, the total minutes of the service performed should be included in the patient record to substantiate the level of service. A total of 8 units of active and passive therapy may be billed per visit. If active therapy is being applied, only one unit of passive therapy may be included in the 8 units.
- Passive therapies (listed in U&T Guidelines) will be limited to 4 units per visit, if only passive therapy is being applied. Note: Only 1 unit may be billed if active therapy is being applied.

98940-98943

Codes 98940-98943, regardless of how many manipulations are performed in any given spinal region; it counts as one region under the CMT codes. If multiple manipulations units are billed in the same region, it will be denied as "Procedure insufficiently identified or quantified." The regions are:

- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic (sacral-iliac and other pelvic articulations)
- Extra-spinal (head, lower or upper extremities, rib cage and abdomen).

99455 and 99456

MSF allows codes 99455 and 99456 by treating and non-treating chiropractors for work related medical disability exams. If not documented as such in the medical record, the bill will deny as "Procedure insufficiently identified or quantified."

- For dates of service through 6/30/13 the applicable fee schedule applies.
- For dates of service on or after 7/1/13, process according to providers U & C.

97139

- Vertebral Axial Decompression (VAX-D)/DRX, 9000 – CPT 97139

Note: CPT codes listed are for clarification purposes only and doesn't constitute acceptance or denial of codes when billed.

20 PHYSICAL AND OCCUPATIONAL THERAPY

Physical Therapy: Rehabilitation concerned with restoration of function and prevention of disability following disease, injury, or loss of body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet and massage are used to improve circulation, strengthen muscles, encourage return of motion and train or retrain an individual to perform the activities of daily living.

The following providers may bill MSF for physical therapy services:

- Licensed Physical Therapist
- Licensed Physical Therapy Assistant (not a Physical Therapy Aide) may bill under their own name without a counter signature from a Physical Therapist. They must practice within their scope of practice. (Note: A Physical Therapy Aide may not bill for services and must be supervised onsite by a licensed physical therapist or assistant).

MCA 37-11-105 states: **Supervision of physical therapist assistant, physical therapy aide, physical therapy student, or physical therapist assistant student.** (1) A physical therapist assistant shall practice under the supervision of a licensed physical therapist who is responsible for and participates in a patient's care. This supervision requires the licensed physical therapist to make an onsite visit to the client at least once for every six visits made by the assistant or once every 2 weeks, whichever occurs first.
(2) A licensed physical therapist may not concurrently supervise more than two full-time assistants or the equivalent. This supervision does not require the presence of the assistant.
(3) A physical therapy aide shall practice under the onsite supervision of a licensed physical therapist or a licensed assistant. A licensed assistant may not concurrently supervise more than one full-time aide or the equivalent. A licensed physical therapist may not concurrently supervise more than four aides or the equivalent or two assistants and two aides or the equivalent.
(4) A physical therapy student or physical therapist assistant student shall practice with the onsite supervision of a licensed physical therapist.

NOTE: *As it is sometimes difficult to distinguish a physical therapy assistant and physical therapy aide as they both may use the initials PTA you may go to the licensee lookup website http://app.mt.gov/cgi-bin/lookup/licenseLookup.cgi to verify licensure of a Physical Therapy Assistant.*

Occupational Therapy: Use of work related skills to treat or train the physically or emotionally ill, to prevent disability, to evaluate behavior and to restore disabled persons to health, social, or economic independence.

Timed Modalities
Services of less than 8 minutes when that is the only service performed during a visit is not billable. Time intervals are incremented in 15 minute units (base is 8 minutes):

8-22 minutes =	1 unit
23-37 minutes =	2 units
38-52 minutes =	3 units etc

- When more than one service of a timed modality is performed in a single day, the total minutes of the service performed should be included in the patient record to substantiate

the level of service. A total of 8 units of active and passive therapy may be billed per visit. If active therapy is being applied, only one unit of passive therapy may be included in the 8 units.

- Passive therapies (listed in U&T Guidelines) will be limited to 4 units per visit, if only passive therapy is being applied. Note: Only 1 unit may be billed if active therapy is being applied.

Billing

- All timed codes must have the time documented (in minutes) in the office notes submitted for each code billed for reimbursement.
- Therapy codes billed must have part of body documented or it must be clearly identified in a flow sheet or other attached documentation. If the procedures are clearly documented in the notes, a flow sheet is unnecessary. If the notes do not support the procedures billed but refers to a flow sheet then the flow sheet must be attached.

97026, 97039 and 97139

- Hot water massage table - CPT 97039
- Infrared light therapy – CPT 97026.
- Cold laser light treatment/Low level laser therapy – CPT 97039.
- Vertebral Axial Decompression (VAX-D)/DRX, 9000 – CPT 97139

Note: CPT codes listed are for clarification purposes only and doesn't constitute acceptance or denial of codes when billed.

97799/MT001 and 99070, 99080

- Refer to Evaluation and Management Section.

21 ACUPUNCTURE

37-13-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Acupuncture" means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities by means of mechanical, thermal, or electrical stimulation effected by the insertion of solid needles. The term includes the use of acupressure and the use of oriental food remedies and herbs.

(2) "Acupuncturist" means a natural person licensed by the board of medical examiners to practice acupuncture.

(3) "Board" means the Montana state board of medical examiners.

(4) "School of acupuncture" means a school in which acupuncture is taught that has been recognized and designated by the board of medical examiners.

97810-97814

For dates of service 1/1/08 and forward - The provider may bill with the standard CPT codes 97810 – 97814.

Reimbursement

If a provider is only billing the initial 15 minutes (97810 or 97813), then time does not have to be documented in the note, however, if a provider bills the initial with the "each additional 15 minutes" codes (97811 or 97814) then total time spent providing the service will need to be documented in the note to substantiate the use of the additional code.

22 MASSAGE THERAPY

37-33-403. Definitions. As used in this chapter, the following definitions apply:

(4) (a) (i) "Massage therapy" when provided by a massage therapist means the application of a system of structured touch, pressure, positioning, or holding to soft tissues of the body, Swedish massage, effleurage, petrissage, tapotement, percussion, friction, vibration, compression, passive and active stretching or movement within the normal anatomical range of motion, the external application of water, heat, cold, lubricants, salts, skin brushing, or other topical preparations not classified as prescription drugs, providing information for self-care stress management, and the determination of whether massage is contraindicated and whether referral to another health care practitioner is recommended.

(ii) The techniques described in subsection (4)(a)(i) must be applied by the massage therapist through the use of hands, forearms, elbows, knees, or feet or through the use of hand-held tools that mimic or support the action of the hands and are primarily intended to enhance or restore health and well-being by promoting pain relief, stress reduction, and relaxation.

(b) The term does not include providing examinations for the purpose of diagnosis, providing treatments that are outside the scope of massage therapy, attempts to adjust, manipulate, or mobilize any articulations of the body or spine by the use of high-velocity, low-amplitude thrusting force, exercise, exercise instruction or prescription, or the use of tape when applied to restrict joint movement, manual or mechanical traction when applied to the spine or extremities for the purposes of joint mobilization or manipulation, injection therapy, laser therapy, microwave diathermy, electrical stimulation, ultrasound, iontophoresis, or phonophoresis.

Massage Therapists: must be currently licensed. MSF doesn't accept Grandfather Clause. Refer to the licensee lookup website http://app.mt.gov/cgi-bin/lookup/licenseLookup.cgi to verify licensure of a Massage Therapist.

Billing

- **For dates of service 7/1/10 and forward -** The providers will only be allowed to bill 97124 (Massage Therapy) and 97010 (Hot/Cold Pack). All other codes should be denied as "Procedure not in provider's scope of practice."
- All timed codes must have time documented ***by code*** in the medical record. Time must be documented in minutes not units.

23 RADIOLOGY BILLING

MSF will accept the following:

Billing

- If both the technical and the professional services were provided in the clinic , the global service should be billed and the service provider NPI should be in box 24J. Signature on notes must match the name associated with the NPI in box 24J on the CMS 1500.
- If the provider is billing only the professional component – modifier 26 – the rendering physician's NPI number should be in box 24J. Signature on notes must match the name associated with the NPI in box 24J on the CMS 1500.
- If the provider is billing only the technical component – modifier TC – the NPI number in box 24J may not belong to the provider whose signature is on the notes.
    - For dates of service through 6/30/13 the above rule applies.
    - For dates of service on or after 7/1/13, providers billing the TC component must bill on a UB04 for those services.
- Locum Tenens – Bills will be accepted when the Q6 modifier is present. Box 31 may indicate Locum Tenen but isn't required for processing the bill. The provider the Locum Tenen is covering for should bill with his/her NPI in box 24J.

Box 32

- Box 32 must be the name and address of the location where services were provided. Provider should bill with the appropriate NPI in box 32a.

Box 33

- Box 33 must be the physician or supplier billing entity name, and address. Provider should bill with the appropriate NPI in box 33a.

Documentation must support the services billed. If there is not an actual radiology report, the documentation in the notes must clearly identify the codes billed and the results.

Reimbursement:

Professional Component	
First subsequent procedure	75%
Second subsequent procedure	50%
Third and all additional subsequent procedures	25%

Technical Component	
First subsequent procedure	50%
Second and all additional subsequent procedures	25%

24 Pathology and Laboratory

Drug Screens performed by a provider that is a CLIA waived test or of moderate complexity per patient encounter must bill using G0434 with 1 unit. This includes dipsticks, cups, cassettes and cards.

Drug screens performed by a CLIA certified lab that is an instrumented laboratory setting and is a high complexity method per patient encounter must bill using G0431.

25 MEDICAL CASE MANAGEMENT

See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

The scope of services to be provided by Medical Case Managers is as follows:

- initial interview with the injured employee,
- coordination of appropriate medical and support services,
- development of a treatment plan designed to facilitate optimal case outcome,
- facilitate delivery of pertinent medical, school, or vocational records to MSF,
- continuing contact with the injured employee, medical providers, claim examiner, and if requested, employer,
- regular reporting to the claim examiner,
- injured employee, and possibly family, education and monitoring to ensure injured employee compliance with recommended medical treatment,
- assessment of appropriate equipment and supplies, and coordination of delivery,
- home domiciliary care assessment.

Billing

- Services should be billed on a CMS 1500 form and must include an ICD-9 diagnosis code.
- Line item billing is required for reimbursement, with billing to be posted in increments of tenths of an hour:
    - .1 = 1-6 minutes
    - .2 = 7-12 minutes
    - .3 = 13-18 minutes
    - .4 = 19-24 minutes
    - .5 = 25-30 minutes
    - .6 = 31-36 minutes
    - .7 = 37-42 minutes
    - .8 = 43-48 minutes
    - .9 = 49-54 minutes
    - 1.0 = 55-60 minutes
- All services provided must be documented in a note for the claim file; i.e., the medical case manager must submit documentation to describe the services provided and a summary of the claim's status. Line item billing with a description of services provided does not meet this requirement. Payment for services will be withheld if these specifications are not met.
- MSF will not reimburse the Contractor for:
    - Uncompleted telephone calls; for example, a call made to an unavailable party for whom a message was left will not be reimbursed.
    - File sorting or copying services.
    - Appointment scheduling services.
    - "Wait" time for medical appointments.
    - Any billed time without supporting documentation in the claim file or notes.
    - MCM reporting in excess of documentation to support services requested and provided.

- Ancillary costs. Supporting documentation will be required for any out-of-pocket expenses or any costs not specifically described in this contract. Pre-authorization is required for reimbursement of any ancillary costs. In the absence of pre-authorization, MSF's claims examiner or medical case manager will review the supporting documentation, determine whether the costs are reimbursable, and render a reimbursement decision.

Reimbursement

The following information is to be used as the fee schedule for medical case management serviced provided to Montana State Fund on referred claims.

MCM CONTRACT RATES FOR FY14		
Internal Code	**ITEM**	**Contract Rate**
RNCM1	Medical case management, up to & including 10.0 hours	$90/hour
RNCM2	Medical case management, over 10.1 hours	$90/hour
LCP01	Life care plan, up to & including 10.0 hours	$90/hour
LCP02	Life care plan, over 10.1 hours	$90/hour
MCMTR	Travel, per hour	$45/hour
A9200	Mileage	Prevailing State Rate

MSF will reimburse travel expenses in accordance with the prevailing reimbursement rate for State employees found at http://doa.mt.gov/doatravel/travelmain.asp .

Genex - TX

- If location is Texas, taxes must be paid. Taxes may be billed with code RNCM1 or other medical expense code. If billing for Voc Rehab services, use code VRSPL.

26 DURABLE MEDICAL EQUIPMENT (DME)/OXYGEN EQUIPMENT AND SUPPLIES

Supplies and equipment billing by an individual provider or non-DME supply house

- **For dates of service 1/1/08 and forward -** When supplies or equipment (other than prescription medications) are provided in an office setting, per ARM 24.29.1522, reimbursement is based on the RVU listed in the RBRVS in effect at the time of service, multiplied by the conversion factor as established (per ARM 24.29.1538) in effect at the time of the service. If a RVU is not listed or is null, the reimbursement if limited to a total amount that is determined by adding the cost of the item plus the freight cost plus the lesser of either $30.00 or 30% of the cost of the item. An invoice documenting the cost must be sent upon request. Providers must use a HCPCS code or if a code does not exist, then 99070 may be used. If 99070 is used, the item must be documented in the note.
    - Note: Invoices aren't required for items with an assigned fee schedule or if the item is $30.00 or less. If the item is $30.00 or less, pay at billed rate.

DME / O2 / Supplies billing by a PPO Provider

- **See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.**

Services include:

- Oxygen Equipment and Supplies
- Durable Medical Equipment
- Bone Growth Stimulators
- TENS Equipment & Supplies
- Orthotics & Prosthetics Supplies & Services

A physician must prescribe the need for services. A treating physician is defined as:

- A person who is primarily responsible for the treatment of a worker's compensable injury and is:
- A physician licensed by the state of Montana;
- A chiropractor licensed by the state of Montana;
- A physician assistant-certified licensed by the state of Montana;
- An osteopath licensed by the state of Montana;
- A dentist licensed by the state of Montana;
- For an injured employee residing outside of state or upon approval of the insurer, a treating physician defined in subsections (36)(a) through (36)(e) who is licensed or certified in another state; or
- An advanced practice registered nurse licensed by the state of Montana.

Reimbursement

- Rate = Medicare fee schedule + 15%, updated quarterly from the Noridian website, rental to purchase price - cap at purchase price, for codes without a Medicare fee schedule pay 80% of charge.
- Repair and adjustment work will be paid on an hourly rate, based on the Medicare reimbursement rate. The vendor is responsible for obtaining pre-authorization from the MSF claim examiner for repair work prior to commencing this work.
    - See the Medicare Repair Fee Schedule for codes K0739, L4205 and L7520.

26.1 General Contract Guidelines for ALL contracted vendors

- All bills must be submitted on a CMS 1500 or UB04 form with HCPCS codes to indicate procedures/supplies and ICD-9 codes to indicate diagnosis. No payment will be made unless billing is properly coded and submitted in accordance with Medicare billing standards. MSF reserves the right to perform periodic audits on amounts charged for specific procedure codes to ascertain that charges submitted do not exceed usual and customary costs, as determined by a review of comparable suppliers**.**
- ***All rental charges paid will be applied toward the cost of purchase, not to exceed the usual purchase cost.*** If the item is a rental item, start and end dates of the rental period must be specified. Return the bill to provider requesting date range if not given on the bill.
- Mileage is not a reimbursable expense under this contract.
- No payment will be made for professional travel time for any service, including delivery of equipment.
- Shipping charges are allowed only on initial purchases. Freight/shipping charges will **not** be reimbursed for rental items.
- MSF reserves the right to re-negotiate reimbursement rates based on extraordinary care circumstances. "Extraordinary Care" is defines as 1) extended physical or medical care of an injured employee that exceeds normal duties expected for the particular diagnosis or 2) extraordinary travel circumstances.
- The Contractor must provide a copy of the signed and dated medical prescription for all equipment.
- Wheelchairs will be replaced no more than once every five (5) years, unless it is medically documented that earlier replacement is required because the current wheelchair is causing serious health/medical problems or because of a significant change in the injured employee's medical condition.
- **The Contractor must be able to provide a system (eg., 'smart' card), free of charge, for monitoring utilization of equipment and injured employee compliance with recommended utilization upon request, and for all bone stimulators.**
- All contracted vendors must accept Montana State Fund payment as payment in full for services rendered and cannot balance bill the Injured Employee.

26.2 DME Rental

General Contract Guidelines apply. **See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.**

Prior Authorization
MSF must **preauthorize** any equipment/supplies with a purchase price of more than $200.00.

Reimbursement
Reimbursement for durable medical equipment will be paid at the amount designated in the Medicare Fee Schedule plus 15%, or at the Contractor's usual rate, not to exceed the amount designated in the Medicare Fee Schedule plus 15%. Any item not designated in the Medicare Fee Schedule will be reimbursed at 80% of usual and customary charges.

Rental to Purchase
All rental charges paid will be applied toward the cost of purchase, not to exceed the usual purchase cost. If the item is a rental item, start and end dates of the rental period must be specified. Use reason code "Rental charges have been applied" and /or "Rental charges apply to purchase price".

- Modifiers are used to differentiate rentals and purchases (i.e. NU = New / RR = Rental).
    - If the rental/purchase modifier is not on the bill, deny as "Modifier missing".
- The Medical Team will audit rental payments for appropriate payment to purchase price quarterly. Once rental to purchase price has been met, future rental bills are denied with reason code "Rental item has been purchased." If the remainder of the purchase price is less than the amount billed, payment will be adjusted to that amount and reason code "Rental charges have been applied" and reason code "Rental item has been purchased" should be entered.

Supply Items
MSF does not pay for certain supply/supplement items unless prescribed by a physician. (Chiropractors are not an acceptable prescriber). Items include but are not limited to: supplements of any kind, vitamins, topical ointments, educational material (books, booklets, pamphlets, etc.), herbal remedies, etc. Deny as "Denied - Vitamins/supplements/education materials not payable" or "Non-reimbursable service-Not billable to injured worker" or "Non-reimbursable service-Billable to injured worker", as applicable.

Shipping and Tax

- Reimbursement of **shipping** charges will be allowed only on initial purchases. Freight/Shipping charges will not be reimbursed for rental items.
- **Sales tax** is not payable. Deny as "Non-reimbursable service-Not billable to injured worker." Contact a Medical Payment Auditor on the Medical Team for determination, if reconsideration is requested.

Unlisted (Dump) Codes
All dump codes must have supporting documentation submitted with the bill for reimbursement and the item should be data entered in the Description field. If no supporting documentation submitted, deny the bill with reason code "Procedure insufficiently identified or quantified".

26.3 Oxygen Equipment and Supplies

General Contract Guidelines apply. **See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.**

Contractor must provide a copy of the signed and dated medical prescription for the provision of oxygen. Prescriptions for oxygen shall include the liter flow per minute, whether continuous use is required or the hours of use per day, the recipient's PO2 or oxygen saturation blood test(s) results, and whether a stationary and /or portable system is used.

The **monthly rental charge will include** the following products and services:

- oxygen refills
- equipment technician visit, and
- all professional travel time and mileage

Prior Authorization
MSF must preauthorize any oxygen equipment/supplies with a purchase price of more than $200.00.

Reimbursement
Reimbursement for oxygen equipment and supplies will be paid to PPO Contractors at the amount designated in the Medicare Fee Schedule plus 15%, or at the Contractor's usual rate, not to exceed the amount designated in the Medicare Fee Schedule plus 15%. Any item not designated in the Medicare Fee Schedule will be reimbursed at 80% of usual and customary charges.

26.4 Orthotics & Prosthetics

All General Contract Guidelines apply. See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

Billing

- All bills must be submitted on a CMS 1500 form with HCPCS codes to indicate procedures/supplies, with ICD-9 codes to indicate diagnosis. ***No payment will be made unless billing is properly coded and submitted.***

Prior Authorization

- Any item with a rental, purchase, or replacement price more than $200.00 must be pre-authorized in writing by a State Fund claims examiner.
- Replacement of orthotics and prosthetics must be pre-authorized by MSF.

Reimbursement
Reimbursement will be based on the codes submitted. Payment will be made according to the Medicare fee schedule plus 15%. Reimbursement for codes not specified by the Medicare fee schedule will be paid at 80% of charge.

- **Exception: <u>Casted Orthotics</u>,** *when billed by a health care provider who is not a PPO provider, should be paid in full, as this gives a value added service and will not apply to the PPO network. This is* ***only*** *for those items that are* ***casted*** *specifically for an IE in the provider's clinic.* **The provider should bill a reasonable fee.**

Repair and adjustment work

Repair and adjustment work will be paid on an hourly rate, based on the Medicare reimbursement rate. The vendor is responsible for obtaining pre-authorization for repair work prior to commencing this work.

Rental to Purchase
Rental to Purchase cap at purchase price, 80% of charge for all other codes. Use reason code "Rental charges apply to purchase price." Once the purchase price has been met, deny with reason code "Rental item has been purchased." If the remainder of the purchase price is less than the amount billed, payment will be adjusted to that amount and reason code "Rental charges have been applied" and reason code "Rental item has been purchased" should be entered.

- Modifiers are used to differentiate rentals and purchases (i.e. NU = New / RR = Rental).

Inclusive codes
No additional reimbursement will be allowed for billing submitted with CPT codes that are considered inclusive when performed in conjunction with other services or supplies. Examples of this are 1) CPT codes 95851 and 95852, range of motion, which are considered inclusive when done in conjunction with the selection, design, alteration or fabrication of orthotics or prosthetics; and 2) CPT code 97116, gait analysis, which includes stair climbing, or motion analysis testing, which is considered inclusive of the charge of an orthotic. Examples given may not represent all possible exclusions. The vendor may contact MSF for verification of appropriate billing procedures.

26.5 Bone Growth Stimulators

All General Contract Guidelines apply. See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

The non-invasive method of electrical bone growth stimulation is considered medically necessary for the treatment of:

- Long-bone non-union (including: humerus, radius, ulna, femur, tibia, fibula, metacarpal, and metatarsal bones). The diagnosis of long-bone non-union must meet ALL of the following criteria:
    - At least three (3) months have passed since the date of the fracture.
    - Serial radiographs over three (3) months show not progressive signs of healing.
    - The fracture gap is 1 centimeter or less.
    - The fracture site can be adequately immobilized.
    - The patient is likely to comply with non-weight bearing requirements.
- Failed joint fusion secondary to failed arthrodesis of the ankle or knee.
- Failed spinal fusion defined as a spinal fusion that has not healed, as evidenced by serial x-rays, over a course of three (3) months.
- Non-union fractures of short bones (i.e., scaphoid, navicular) when the following criteria are met:
    - Non-union is established when serial x-rays show no visible signs of healing of a period of three (3) months with alternative treatments.
    - The fracture gap is one (1) centimeter or less.

The non-invasive or invasive methods of electrical bone stimulation are considered medically necessary as an adjunct to spinal fusion surgery for individuals with one or more of the following risk factors:

- Fusion to be performed at more than one level.
- Previous unsuccessful spinal fusion attempts.
- Grade II, or worse, spondylolisthesis.

- Current, or very recent, smoking habit.
- Osteoporosis, diabetes, or other metabolic diseases which influence bone healing
- Renal disease
- Obesity
- Alcoholism

Low-intensity ultrasound treatment is considered medically necessary when used:

- As an adjunct to conventional management (e.g., closed reduction and cast immobilization) for the treatment of fresh (< 7 days), closed fractures in skeletally mature individuals.
- As a treatment of non-union fractures, excluding the skull and vertebra.

All bone growth stimulator prescriptions, unless otherwise specified by the treating physician, will be filled with a non-invasive device rather than an implanted bone growth stimulator.

Prior Authorization
All bone growth stimulators must be pre-authorized by a MSF claim examiner in writing. The Contractor must provide a copy of the signed and dated medical prescription for any bone growth stimulator.

Reimbursement
Reimbursement for bone growth stimulators will be paid to Contractors at the amount designated in the Medicare Fee Schedule, or at the Contractor's usual rate, not to exceed the amount designated in the Medicare Fee Schedule. Any item not designated in the Medicare Fee Schedule will be reimbursed at 80% of usual and customary charges.

26.6 Tens Equipment and Supplies

General Contract Guidelines apply. See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

All TENS orders, unless otherwise specified by the treating physician, will be filled with a basic device.

The following items/services will be included as part of the rental or purchase price of any TENS unit:

- Items included as part of the rental or purchase price of any TENS unit: carrying case, lead wires, batteries, and a battery charger. Once a unit has been purchased MSF will pay for replacement batteries, and annual replacement of lead wires unless a more frequent supply is pre-approved by the claim examiner in writing (Note: Once a unit has been purchased, ACS is instructed to also pay for replacement battery chargers and carry cases. The CE will make the final determination as to whether the supply will be covered by MSF);
- Shipping and handling, including next day express when necessary;
- Provision of initial usage training instructional visit with a certified clinician at no charge;
- All rental applied to the purchase price of any device, and;
- A cap on rental to be paid on all units.

Prior Authorization

- Reimbursement for any miscellaneous code without prior authorization will be denied as "Denied - Per insurance carrier decision" and add reason code "Prior authorization required."
- Any TENS/electro-medical equipment with a purchase price more than $300.00 must be pre-authorized by the MSF claim examiner in writing.
- Replacement of a battery charger may be billed on purchased units only and require written prior authorization from the claim examiner.

Reimbursement

Contractor will be reimbursed at usual and customary rates, not to exceed the amount established by MSF for each associated HCPC code. Any TENS-related item not designated in the MSF fee schedule will be reimbursed at 80% of the usual and customary charges or Medicare plus 15%, whichever is less.

Rental to Purchase

Rental to Purchase cap at purchase price, 80% of charge for all other codes. Use reason code "Rental charges apply to purchase price." Once the purchase price has been met, deny with reason code "Rental item has been purchased." If the remainder of the purchase price is less than the amount billed, payment will be adjusted to that amount and reason code "Rental charges have been applied" and reason code "Rental item has been purchased" should be entered.

- Modifiers are used to differentiate rentals and purchases (i.e. NU = New / RR = Rental).

Replacement Battery Charger

Replacement of a battery charger applies to purchased units only, and requires prior authorization by the Claim Examiner.

E1399 can only be used on equipment or supplies for which there is not a more appropriate code. A description must be entered on the CMS 1500. E1399 may be used to bill Shipping and Handling and the Interferential II (IFFY II).

TENS EQUIPMENT AND SUPPLIES CONTRACT RATE FOR FY14		
HCPC	**ITEM**	**Contract Rate**
A4556	Electrodes (1 unit = 2 electrodes)	Medicare Fee Schedule
A4557	Lead Wires (1 unit = 2 lead wires); limit to annual replacement for purchased units only.	Medicare Fee Schedule
A4558	Conductive Paste or Gel	Medicare Fee Schedule
A4595	Elec Stim supplies for 2-lead unit, per month	Not an allowed code
A4630	Replacement Batteries (TENS unit) – payable on purchased units	Medicare Fee Schedule
E0720NU	TENS Unit (2-LEADS) – Purchase	Medicare Fee Schedule
E0720RR	TENS Unit (2-LEADS) – Rent	Medicare Fee Schedule/10
E0730NU	TENS Device (4 or more LEADS) – Purchase	Medicare Fee Schedule
E0730RR	TENS Device (4 or more LEADS) – Rent	Medicare Fee Schedule/10
E0731NU	Form Fit conductive garment (Purchase)	Medicare Fee Schedule
E0745NU	Neuromuscular Stimulator (Purchase)	Medicare Fee Schedule x 10
E0745RR	Neuromuscular Stimulator (Rental)	Medicare Fee Schedule
E1399NU	Interferential (IFFY II Only) Purchase	80% UCR
E1399RR	Interferential (IFFY II Only) Rental	$75.00/mo up to amount of purchase limit

27 INDEPENDENT MEDICAL EXAMINATION (IME)

See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

MSF had contracted providers prior to 07/01/03 that performed IMEs with designated billing codes for their use only. From 7/01/03 through 6/30/05 there were no contracted providers for this service.

An independent medical examination (IME) is done when MSF wants another physician's opinion, other than the injured employee's treating physician. An IME is an evaluation by a physician, psychologist, or other specialist other than the injured employee's primary treatment provider intended to provide additional information, clarification, and/or recommendations about specific issues. The IME may address multiple issues that are involved in the management of a claim. An independent panel evaluation is an evaluation by a team of specialists appropriate to the particular case. (Note: A separate bill will be received for each Panel IME provider.)

IME CONTRACT RATES FOR FY14		
Code	**Item**	**Contracted Rate**
IME01	Administrative Fee, single IME or panel **Note: Contracted vendors are allowed only one IME01 per single IME or panel review.**	$300
IMENO	No Shows and Cancellations, **Note: Contracted vendors are allowed only one IMENO per single IME or panel review.**	$200
MDFEE	Physicians Fee (medical, psych, neuro psych, etc.)	$1,200
DCFEE	Chiropractic fee	$500
MDFNO	No-shows and cancellations: < / = 72hours > 72 hours	 Full Fee $0
MDF01	Additional Questions (submitted after exam)	$100/total
MDF02	Multivolume files or multi-claim examinations	MSF Review
A9200	Provider travel reimbursement	MSF Review
CPT Code(s)	Testing	Paid at fee schedule

Contracted Providers

Diagnostic testing/x-rays
Diagnostic testing and x-rays will be reimbursed at MSF fee schedule.

Travel
IE travel expenses are to be advanced to the injured employee as defined in 24.29.1409, ARM and MSF will reimburse the Contractor. Travel expenses will be reimbursed at 100% even in the case of a no-show for any reason.

96100
Psychological evaluations, code 96100, reimburse at fee schedule **unless otherwise requested by the examiner**.

99080
If code 99080 is billed for an IME, deny as "Denied - Invalid CPT/HCPCS/ADA/NDC code."

99199 or 99499
IMEs requested by Employee Relations Division (ERD), codes 99199 or 99499, are to be paid full for the physician's services. All diagnostic testing and x-rays are to be reimbursed at fee schedule.

Non-Contracted Providers

Not all IME providers will be contracted. Non-contracted providers must bill with accepted CPT/HCPCS codes and bill using a CMS 1500 form.

99241-99245 and 99354-99359
Non-contracted providers may bill consultation codes 99241-99245 with a -25 or -32 modifier. 99354, 99355, 99358, and 99359, extended time, may be billed in addition to the above codes, however, **time must be documented** and the use of the code(s) must be in accordance with CPT guidelines.

99082

- Non-contracted physician travel is reimbursable, code 99082, if the provider traveled from their primary office site to another office site (not a satellite office) in order to perform the evaluation even if the IE is a no-show, which is reimbursed at 100%.
- IE travel expenses are to be advanced to the injured employee as defined in 24.29.1409, ARM and MSF will reimburse the Contractor.

99199 or 99499
Codes 99499 may be billed for non-contracted IME providers. As this is a BR code, this will pay in full.

28 IMPAIRMENT RATING

Effective Dates

- **For dates of service 1/1/08 and forward -** please refer to the RBRVS and ARM rule 24.29.1522.

Please see the full description of these codes in the current CPT or Relative Values for Physicians books.

99455 – work related or medical disability examination by the treating physician; and
99456 – work related or medical disability examination by the non-treating physician.

- For dates of service from 1/1/08 through 6/30/13, DOLI established the following RBRVS values:
  - 99455 2.5 RVU
  - 99456 2.8 RVU

- For dates of service on or after 7/1/13, 99455 and 99456 will be paid at U&C as there are no values associated with these codes.

Billing

- Only one (1) unit is allowed per date of service for the impairment rating codes and paid at the fee schedule in effect at the time of service.
- The documentation MUST include an exam of the Injured Employee and the calculation of impairment, which is the percent of the person's body that is injured, using the 6th edition of the Guides to Evaluation of Permanent Impairment published by the American Medical Association. The documentation need not specify the exact page number, but do need to reference the source of calculation. This code is typically billed when the injured employee reaches **maximum medical improvement** (MMI). If the injured employee reached MMI prior to 1/1/08, then the 5th Edition of the Guides to Evaluation of Permanent Impairment should be used. If the injured employee reached MMI on or after 1/1/08, then the 6th Edition must be used.
  - **Maximum Medical Improvement (MMI)** - MCA 39-71-116 (21) "Medical stability", "maximum medical improvement", "maximum healing", or "maximum medical healing" means a point in the healing process when further material functional improvement would not be reasonably expected from primary medical services.

Non-Treating

- **For dates of service 1/1/10** through **6/30/13** – 99456 or a consultation code may be billed for an impairment rating by a non-treating provider**.** If a consultation code is billed, 99358 and 99359 may be billed for records review. Time must be documented.
- **For dates of service on or after 7/1/13, providers will need to bill with 99456.**

99080

Under most circumstances, code 99080 CANNOT be billed with codes 99455 or 99456. Deny the 99080 as "Included in another billed procedure."

99199 or 99499

Impairment Rating "no shows" may be billed with codes 99199 or 99499.

29 VOCATIONAL REHABILITATION

See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

The objective of MSF is to return an injured employee to work as soon as possible after a work related injury or occupational disease. To assist MSF in meeting this objective Vocational Rehabilitation Contractors will provide services defined in the contract upon the request of MSF adjustor for the compensation outlined therein. Services will commence upon the referral of the claim to the contractor by MSF claims examiner. Referrals will be made by Phase as defined below.

Billing

- Services must be billed on a CMS 1500 form or an invoice. The same information required on the CMS 1500 form is also required if billing on an invoice. All bills must have supporting documentation to support services provided, including dates of service (a date span is acceptable). Diagnosis code 959.9 is sufficient.
- Documentation for each code must be submitted with bill for payment consideration. Each document must be signed and dated.
- Modifier OS (out-of-state) may be added by out-of-state vendors to any service related code for an additional 10% add on to the contract amount. OS does not apply to any incentive or expense codes (i.e., VRTRT, VRTRV, VRTRM, VRTRH, INC01, INC02, INC04, INC05, INC06, INCO7, AND INC08).

Reimbursement

Travel time will be reimbursed to the contractor at $42.00 per hour. MSF will reimburse travel expenses (to include mileage, meals, and lodging) in accordance with the prevailing reimbursement rate for State employees found at http://doa.mt.gov/doatravel/travelmain.asp.

CONTRACT FOR VOCATIONAL REHABILITATION SERVICES

(Claims with a date of injury after 7/1/90)

(Valid for Services beginning 7/1/12)

PHASE I (NEW FUND)

	Action	Expectations of CRC Actions	Code	Flat Fee	Due Date
A	TOI JA	• completed with the IE and the IE's employer/direct supervisor at IE's work site • obtain employer/direct supervisor and IE signature to verify participation • ascertain whether employer will modify job/provide alternative work • provide copies to MD, employer, IE (or attorney), and examiner • Contractor's bill may be submitted once the doctor's signature is received.	JA008	$394	Within 14 days of assignment

PHASE II (NEW FUND)

	Action	Expectations of CRC Actions	Code	Flat Fee	Due Date
A	ERTW Coordination	• obtain employer commitment for ERTW (TOI job or modified job)	ERTW (retired	$331	Within 14 days of

		• may include in-person meetings • Includes counseling the IE and employer on SIF certification process	code 6/30/12)		assignment
B	SARTW	• obtain employer commitment for SARTW (TOI job or modified job) • may include in-person meetings • Includes counseling the IE and employer on SIF certification process	SARTW	$331	Within 14 days of assignment
C	Modified/ Alternative JAs with TOI Employer	• JAs must be reasonable and reflect IE's capability and qualifications • Includes counseling the IE and employer on SIF certification process	JAALT	$273 Each	Within 14 days of assignment (& 30+ days of monitoring)
PHASE III (NEW FUND)					
	Action	**Expectations of CRC Actions**	**Code**	**Flat Fee**	**Due Date**
A	Employability and Wage Loss Assessment	• info from all pertinent sources assessing work history, education, transferable skills, permanent physical restrictions, wages, and employment potential or RTW options • IE's specific perm restrictions, direct placement capability	EWLA	$1,100	Within 30 days of assignment
	Employability and Wage Loss Assessment	• will provide the background portion of this service i.e. education, previous employment, vocational history, any transferable skills, hobbies, military history, capabilities and permanent physical restrictions.	EWLA1	$650	
	Employability and Wage Loss Assessment	• will provide the assessment portion of the service, which includes: IE's employment and return to work potential expectation, development of a return to work plan and determination of rehabilitation needs.	EWLA2	$450	
B	Alt JA	• JAs must be reasonable, reflect IE's capability and quals, includes wage and Labor Market info	JAALT	$273 Each	Within 30 days of assignment
C	Vocational Testing	• Define the IE's basic skills and aptitudes and/or establish training needs • done on as-needed basis and only with prior consent of examiner • report may be separate or as addendum to EWLA • testing may not be subcontracted	VRTST	$478	
PHASE IV (NEW FUND)					
	Action	**Expectations of CRC Actions**	**Code**	**Flat Fee**	**Due Date**
A	Initial Assessment / Preliminary Report	• will follow recommendations of EWLA must consider OJT/Internships and cite the specific vocational goal • will include costs and duration • draft plan will be submitted to examiner for review prior to IE review	VRPLN	$250	Within 30 days of assignment
B	Plan Completion	• preliminary report submitted to the CE; may include OTJ training, retraining or a combination of both w/ a a specific vocational goal	PLNDV	$650	Within 14 days of assignment

C	Monitoring Plan	• frequency of reporting determined by examiner- describes IE's progress and potential barriers to completion and includes documentation from grade reports and/or updates from mentor/trainer	VRMON	$137/ rpt	
D	Job Placement Assistance	• • IE placement services, including resume preparation assistance for up to 6-weeks of job placement assistance.	PLACE	$550	
E	Addt'l Job Placement Assistance 1	• 2 additional weeks (8 weeks total)	PLAC1	$150	
F	Addt'l Job Placement Assistance 2	• 2 additional weeks (10 weeks total)	PLAC2	$150	
G	Addt'l Job Placement Assistance 3	• 2 additional weeks (12 weeks total)	PLAC3	$150	
D	Completion of Alternate Plan	• ***will update previously completed plan that examiner considers outdated*** • will develop alternate plan at examiner request	VRREV	$158	
PHASE V (NEW FUND)					
	Action	**Expectations of CRC Actions**	**Code**	**Flat Fee**	**Due Date**
A	Subsequent Injury Fund Registration	• will assist IE in SIF registration • at examiner request only and if not Included in previous request for services	VRSIF	$137	Within 14 days of assignment
B	Soc Sec Disability Registration	• will assist IE in SSDI registration • at examiner request only	VRSSD	$263	Within 14 days of assignment
C	Litigation	• consultation with MSF legal staff • time in deposition or court	VRLIT	$84/hr	
D	Customized/ Special Services	• At examiner request only • Billed by report	VRSPL	$84/hr as agreed by the CE	Per agreement with examiner
	Travel time	• Contractor Travel time from nearest of listed cities and/or CRC's normal location (whichever is closest) per trip.	VRTRT	$42/hr	
	Mileage reimbursement	• Actual mileage traveled from nearest of listed cities and/or CRC's normal location (whichever is closest) per trip.	VRTRV	State Rate @ time of travel	
	Meals	• Paid at prevailing State rate. Contractor must designate meal(s) to be paid on bill, eg., breakfast, lunch, dinner.	VRTRM		
	Lodging	• Paid at prevailing State rate.	VRTRH		
	Other Expenses	• Contractor is responsible for and will not charge MSF for administrative expenses, telephone charges, clerical and reporting charges, copying and/or postal charges.			

OLD FUND (Claims with a date of injury prior to 7/1/90) (*Valid for Services beginning 1/1/12*)					
PHASE VI (OLD FUND)					
	Action	**Expectations of CRC Actions**	**Code**	**Flat Fee**	**Due Date**
A	Old Fund: Basic File Review	• 0-5.0 billable hours • Requires Claim Specialist approval • ascertain if IE can RTW or participate in rehab plan • written summary + recommendations required from CRC	OFBAS	$331	Within 30 days of referral or at examiner direction
B	Old Fund: Extended File Review	• >5.1 billable hours • If Contractor thinks more extensive than basic review and it is pre-approved by Team Leader • ascertain if IE can RTW or participate in rehab plan • written summary + recommendations required from CRC	OFEXT	$929	Within 30 days of referral or at examiner direction
C	Old Fund: Employability and Wage Loss Assessment	• info from all pertinent sources assessing work history, education, transferable skills, permanent physical restrictions, wages, and employment potential or RTW options • IE's specific perm restrictions, direct placement capability • loss of labor market analysis for claims prior to 7/1/87	OFWLA	$1,050	Within 30 days of assignment
D	Old Fund: Job Analyses, TOI or Alternative	• JAs must be reasonable. reflect IE's capability and quals, and include wage info • limit of 3 JAs unless examiner requests more	OFJAS	$394 each	Within 30 days of referral
E	Old Fund: Litigation	• consultation with MSF legal staff • time in deposition or court	OFLIT	$84/hr	
F	Old Fund: Subsequent Injury Fund Registration	• will assist IE in SIF registration • at examiner request only and if not included in previous request for services	OFSIF	$137	Within 14 days of assignment
G	Old Fund: Soc Sec Disability Registration	• will assist IE in SSDI registration • at examiner request only	OFSSD	$263	Within 14 days of assignment
H	Customized/ Special Services	• At examiner request only • Billed by report	OFSPL	$84/hr as agreed by CE	Per agreement w/ examiner
	Travel time	• Contractor Travel time from nearest of listed cities and/or CRC's normal location (whichever is closest) per trip.	VRTRT	$42/hr	
	Mileage reimbursement	• Actual mileage traveled from nearest of listed cities and/or CRC's normal location (whichever is closest) per trip.	VRTRV	State Rate @ time of travel	
	Meals	• Paid at prevailing State rate. Contractor must designate meal(s) to be paid on bill, eg., breakfast, lunch, dinner.	VRTRM		
	Lodging	• Paid at prevailing State rate.	VRTRH		
	Other Expenses	• Contractor is responsible for and will not charge MSF for administrative expenses, telephone charges, clerical and reporting charges, copying and/or postal charges.			

INCENTIVES

(Valid for Services beginning 7/1/08)

Incentive payments are intended to instill a sense of urgency and effectiveness in the vocational rehabilitation effort. Incentive payments may be made to the Contractor for the Contractor's successful efforts in the return to work process. All requests for incentive payments will be sent to the examiner, who will assess the Contractor's role in the process.

Only one incentive payment may be paid for each Phase type. With the exception of Alternative JA's. requests for multiple incentives on a single phase will not be honored.

The following definitions and conditions will be applied in the determination whether the incentive is authorized:

Facilitates means due to the efforts of the Contractor. The incentive is not automatically authorized upon the IE's return to work. The Contractor's reports must demonstrate that the Contractor's efforts made a timely and significant difference in facilitating the IE's return to work.

Successful means that the return to work must be successful. The IE must remain gainfully employed in the position for at least 30 days prior to consideration of the incentive payment, unless indicated that return to work must be of greater duration.

Billing must be submitted within 10 days after the IE successfully (after 30 days) returns to the facilitated return to work. The Contractor will provide documentation to support its claim for the incentive showing that the Contractor both facilitated the return to work and that the return to work was successful, as well as dates and wages involved.

Date of referral refers to the date the examiner either made the referral or acknowledged the need for the referral by e-mail and/or in the file notepad entry to the phase services. Phases eligible for incentive payments are described in the following table:

VOC REHAB INCENTIVE FEE MATRIX *(Valid for Services beginning 7/1/06)*			
PHASE II, III			
Action	***Expectations of CRC Actions***	***Code***	***Flat Fee***
JAALT Development of an alternate or modified job analysis either at TOI ER or elsewhere	• *Contractor develops an Alternate/Modified JA that is approved by the treating doctor. Payable for each approved ALT JA up to 3.*	*INC01*	*$100 Each*
Successful SSDI App	• *Contractor develops a SSDI application that is approved*	*INC02*	*$500*
ERTW full-time at mod/alt job within 30 days of Phase II referral	• *Contractor facilitates RTW placement for IE at TOI employer* • *RTW is successful-* ○ *If no wage loss incentive paid at full value.* ○ *If wage loss @ $ 2/hr or less incentive paid at 1/2 of full value.* ○ *If wage loss greater than $ 2/hr incentive paid at ¼ full value.*	*INC04*	*$975*
ERTW full-time at mod/alt job within 60 days of Phase II referral	• *Contractor facilitates RTW placement for IE at TOI employer* • *RTW is successful-* ○ *If no wage loss incentive paid at full value.* ○ *If wage loss @ $ 2/hr or less incentive paid at 1/2 of full value.* ○ *If wage loss greater than $ 2/hr incentive paid at ¼ full value.*	*INC05*	*$650*
ERTW full-time at mod/alt job within 90 days of Phase II referral	• *Contractor facilitates RTW placement for IE at TOI employer* • *RTW is successful-* ○ *If no wage loss incentive paid at full value.* ○ *If wage loss @ $ 2/hr or less incentive paid at 1/2 of full value.* ○ *If wage loss greater than $ 2/hr incentive paid at ¼ full value.*	*INC06*	*$325*
PHASE IV, VI			
Action	***Expectations of CRC Actions***	***Code***	***Flat Fee***
Return to TOI wage following OJT training	• *includes OJT training* • *IE return to TOI wage (paid by employer) within 6 months of commencing OJT training* • *paid after 6 months of employment* • *Not applicable for retraining plans that do not include an OJT/internship component as at least 1/3rd of the time in the plan.*	*INC07*	*$1,300*
Successful RTW for IE deemed perm total	• *Contractor implements rehab plan previously determined as PT by MSF or adjudicated as PT* • *successful RTW for 6 months*	*INC08*	*$3,200*

30 HOME HEALTH

See current Fiscal Year Preferred Provider Organization (PPO) Provider listing for participating providers.

Home Health services are provided to injured workers suffering from injuries or occupational diseases under the Workers' Compensation and Occupational Disease Acts of Montana through preferred provider contracts with home health/home based therapy suppliers. These providers will provide home health services, which is defined as those services which provide home care and related supplies, or home-based therapy (through Independent Practice Consultants) to injured workers who have experienced industrial injuries or occupational diseases and are insured and covered by MSF.

Home health aide services/personal care assistance: include assistance with activities of personal care and daily living (ADL). These services must be provided under the supervision of a registered nurse and in accordance with a written plan of care prescribed by the treating physician.

Physical Therapy: the evaluation, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain, injury, and any bodily or mental conditions by the use of therapeutic exercises, prescribed topical medications, and rehabilitative procedures for the purpose of preventing, correcting, or alleviating a physical or mental disability.

Speech Therapy: services rendered by a speech-language pathologist to employees with a communication disorder.

Occupational Therapy: the use of purposeful activity and interventions to achieve functional outcomes to maximize the independence and the maintenance of health of an individual who is limited by physical injury or illness, psychosocial dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment, or an adverse environmental condition. These services encompass assessment, treatment, and consultation. These services may be provided individually, in groups, or through social systems.

Maintenance Care: treatment designed to provide the optimum state of health while minimizing recurrent of the clinical status.

Palliative Care: treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

Extraordinary Care: 1) physical care of an injured worker that exceeds normal duties expected for the particular diagnosis or 2) extraordinary travel circumstances, such as severe weather-related conditions.

Requirements

- A Physician must prescribe the need for services. Pre-authorization of payment for services by MSF is required.
- All contracted providers must accept MSF payment as payment in full for services rendered and not charge an injured worker additional fees. A contracting agency may not bill the injured worker for any charges not authorized for payment by MSF.
- Progress or therapy notes must be presented with billing in order for payment to be made. Handwritten notes must be legible; illegible notes will be returned to the provider for clarification.
- Billing for reimbursement must be submitted on a CMS 1500 form using the codes specified in the fee schedule.

Reimbursement for home health/home based therapy services shall be the lowest of the following:

- The provider's usual and customary (billed) charges, or
- The rate of reimbursement established by MSF fee schedule.

HOME HEALTH CONTRACT RATES FOR FY14		
Code	**Service**	**Fee Schedule**
HHHA1	Home Health Aide, Skilled	$ 65.00/visit
HHHA2	Home Health Aide, Private Duty /hr	$ 21.00/hour
HHLN2	Home Health Licensed Practical Nurse, Private Duty /hr	$ 40.00/hour
HHPT1	Home Health Physical Therapy, Skilled	$120.00/visit
HHOT1	Home Health Occupational Therapy, Skilled	$120.00/visit
HHRN1	Home Health Registered Nurse, Skilled	$120.00/visit
HHRN2	Home Health Registered Nurse, Private Duty /hr	$ 55.00/hour
HHST1	Home Health Speech Therapy, Skilled	$120.00/visit
HA1TR	Home Health Aide, Skilled –Travel /hr	$ 16.25/hour
HA2TR	Home Health Aide, Private Duty- Travel /hr	$ 5.25/hour
LN2TR	Home Health LPN, Private Duty- Travel /hr	$ 10.00/hour
PT1TR	Home Health Physical Therapy, Skilled – Travel /hr	$ 30.00/hour
OT1TR	Home Health Occupational Therapy, Skilled-Travel /hr	$ 30.00/hour
RN1TR	Home Health Registered Nurse, Skilled – Travel /hr	$ 30.00/hour
RN2TR	Home Health Registered Nurse, Private Duty- Travel /hr	$ 13.75/hour
ST1TR	Home Health Speech Therapy, Skilled –Travel /hr	$ 30.00/hour
A9200	Mileage	Prevailing state rate
HCPCS	Medications/Supplies	Medicare fee schedule + 15%

Visits equal up to two hours.

- MSF will reimburse travel expenses in accordance with the prevailing reimbursement rate for State employees found at http://doa.mt.gov/doatravel/travelmain.asp . Mileage reimbursement will be paid only when travel exceeds 15 miles from the city of origin. Local travel (15 miles or less) is not subject to reimbursement.
- MSF reserves the right to negotiate a modified price with any vendor if/when a injured worker requires extraordinary care as defined by the Fund.

31 DENTAL SERVICES

Billing
Dental bills must include all required information and must be billed on a CMS 1500 form or a ADA Dental form using appropriate codes.

- Dental bills are not required to have notes in order to be processed, as long as all information needed in shown on the bill.

32 MORTUARY

All Mortician and burial services are paid per MCA rule 39-71-725 which states: "Payment of burial expense. There must be paid, in case of the death of an employee whose death is the result of an accidental injury arising out of the employment and happening in the course of the employment, the reasonable burial expenses of the employee, not exceeding $ (**see most current rule for amount**). The payment is not a part of the compensation that might be paid but is a benefit in addition to and separate from compensation."

33 CLAIM CENTER

33.1 Adding Vocational Rehabilitation

In the Time Loss Exposure Benefits page there is an array to capture information for the vocational rehabilitation services that have been requested and/or performed on a claim. The array will capture the name of the rehab company as well as the CRC. The tricky part has been getting the providers to populate the drop down boxes in the array. This was due to the fact some were not in Address Book correctly, and others weren't there at all.

All Certified Rehabilitation Counselors (CRC's) & Vendors are now listed in Address Book so you can add them to your claims. The CRC's are listed by name and their information is updated based on the most recent information in the portal. As a result you will be able to find their contact information quickly (i.e. phone number, fax number, email address).

The following outlines the process in adding these providers. IF the parties are already listed on the claim you will not need to add them again, you may only need to modify their role (step 8 of this process).

To Add the Rehab Vendor (i.e. Crawford)

1. Go to Parties Involved
2. Click the Search Button – Search Address Book page displays
3. Search on Type – Organization
4. Enter the name of the Vendor
5. Click Search
6. Select the appropriate entry (this places the vendor into Claim Parties)
7. Click Add in the Claim Roles Array
8. Select role of Vendor and Rehab Phase Provider. Owner field must be 'none selected', enter the start date
9. Click update

To Add the CRC to the claim

1. Go to Parties Involved
2. Click the Search Button – Search Address Book page displays
3. Search on Type – Person
4. Search on Contact Class – Vendor Provider
5. Enter first & last name of the CRC
6. Select the appropriate entry (this places the CRC into Claim Parties)
7. Click Add in the Claim Roles Array
8. Select role of Certified Rehabilitation Counselor and Vendor. Owner field must be 'none selected', enter start date
9. Click Update

At this point you can go to the Time Loss Exposure Benefits screen – select edit & add a line to the Phases of Rehab array & the parties you entered above will display in the appropriate drop down box!!!

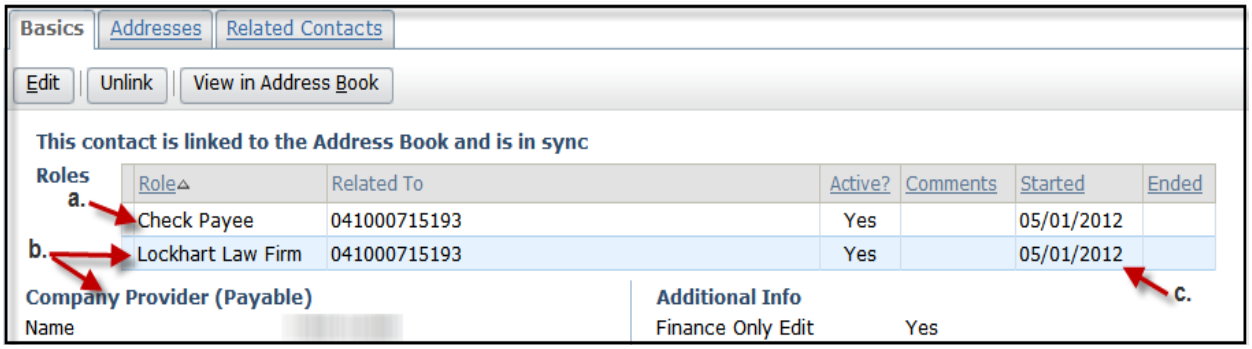
33.2 Adding Mediators to the Litigation Page

The Mediators have also been entered into the Address Book. You will be able to add a mediator when you are entered a New Matter for an upcoming mediation. The following outlines the process in adding the Mediator to the Matter.

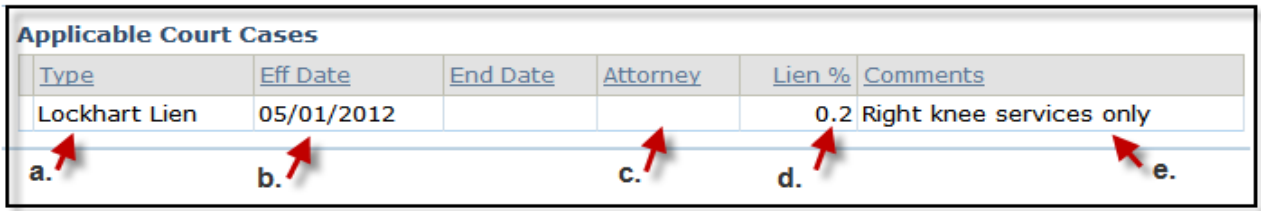
1. Enter the mediation by selecting 'New Matter' page action (you can also create it by opening the Litigation page & click the New Matter button).
2. Enter the basic details for the mediation (the Mediator field will not display upon initial entry)
3. Select Update
4. Click on the name of the Mediation you just entered (this will reopen the mediation page & the Mediator field will now display in the column on the right)
5. Click Edit
6. In the Mediator field click 'Find'
7. Enter search details for the name of the mediator
    a. Type – Person
    b. Contact Class – Vendor Provider
    c. Enter first & last name
8. Click Search
9. Select the name of the Mediator (this populates the mediators name into the field in the litigation screen)

33.3 Adding Lockhart Lien in Claim Center

1. PARTIES INVOLVED - add the Law Firm handling the Lockhart Lien; assign roles:
    a. Check Payee
    b. Lockhart Law Firm *(Law firm must be set up in Address Book as a Company Provider (payable). If not, Finance must be requested to add the Law Firm to Address Book.*
    c. Enter the Start Date for the role: Enter the date the lien became effective.



2. LOSS DETAILS - complete the "Applicable Court Cases" array; add the Lockhart Lien:
   a. Type: Lockhart Lien
   b. Effective Date: The date the Lien became effective. ***Enter the same date as entered for the role start date.***
   c. Attorney: Optional entry - *attorney must be listed in Parties Involved with the role of Lockhart Attorney.*
   d. Lien %: Percentage of lien on this claim – ***Percentage must be listed in decimal form.***
   e. Comments: The POB or tx details Lockhart applies to must be specified. ***This information is fed to ACS.***



33.4 Paying Bills through Claim Center

PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER	
FIELD	**DESCRIPTION**
Financials	This is to determine whether or not the reserves are sufficient to process the bill. If the claim is closed and there aren't any reserves left on it, the bill can still be entered for payment as this will not affect the status of the claim. However, if the claim is open and there are no reserves left on it, entry of the bill on the claim will cause the claim to automatically close. Please request the CE add reserves to the claim before proceeding. If no reserves have been added to the claim or no payments have been made, reserves will need to be added before the bill can be entered for payment.
Actions	(on the left hand side of the screen) and select Check on drop down list
STEP 1 OF 3: ENTER PAYEE INFORMATION SCREEN	
Name	Click on drop down arrow and select the name of the provider. If the provider is not listed in that claim's parties involved, click on the arrow beside the drop down arrow. This will bring up another drop down list – select Search. This will bring up a new screen named Search Address Book. Type – click on drop down arrow to change the type to Company. In the blank next to Tax ID enter the provider Tax ID number using the "dash." For example: 99-9999999. Then click on Search. This will bring up the provider listed in Claim Center's address book that is associated with this particular Tax ID number. Click on Select if this is the correct provider.
Type	This should auto-fill with Vendor. If not, please select Vendor.

Check Delivery	If documentation needs to be sent along with the check being created in Claim Center, change the Check Delivery from 'Send' to '**Hold for Finance**' on the Check Details Screen. Either the Med Team or the CE will then need to email STF Finance and let the Finance team know that the check is coming to MSF.
Next	Will take you to new screen.
STEP 2 OF 3: ENTER PAYMENT INFORMATION SCREEN	
Reserve Line	Click on the drop down arrow and select the appropriate Pay Category. If the correct category is not listed, select New and complete the following. Exposure – select Medical Details Cost Type – Select Claim Cost or Loss Adjustment Expense Cost Category – Select appropriate category.
Exposure	Select Medical Details
Service Dates	Click on the calendar next to the blank line beside Service Period Start – Select month, day, year of first day of service rendered. Click on the calendar next to the blank line beside Service Period End – Select month, day, year of last day of service rendered.
Amount to Post	Type in the amount due in the Amount blank. Please check the figures on the bill as they are often incorrect.
Comments	Enter appropriate comment.
Next	Will take you to new Screen
STEP 3 OF 3: SET CHECK INSTRUCTIONS	
Link Documents	If paying a bill that has been imaged in documents, click Link Documents. Click Select once the correct document is found. Screen will go back to Set Check Instructions Screen. Do the following. Documents Linked to Payment – click on View and add sticky note to the image indicating the bill was entered in Claim Center and close the image OR if the image isn't correct, close the image and click remove. Try linking the correct document again.
Finish	Review the information listed on page. If it is correct, click Finish. This will then go to the Checks page and the bill payment process is complete. If it is not correct, click Cancel and begin again.

33.5 Foreign Country Vendor Setup Process

- Medical Team brings invoice(s) to Finance.
- Finance contacts vendor to obtain W-8BEN (Foreign Status for US Tax Withholding purposes)
    - Foreign Country must send original W-8BEN form via US mail; i.e., it may not be faxed or scanned.
- Finance completes DOA Vendor Information form and attach W-8BEN
    - Deadhead to DOA/Warrant Writer Unit
- Finance will periodically check in SABHRS to verify vendor has been added to statewide accounting system.
- Once verified, Finance will enter vendor in Claim Center.
    - Vendor ID: 00-0000099
        - Same vendor ID must be used for all payments going to a foreign country due to interface process.
        - Previous foreign vendor has to be deleted in Claim Center so next foreign vendor may be added.
    - Government Classification: 99
    - Enter correct country code found in SABHRS; eg., CAN = Canada
    - When adding country code into Claim Center, drop down box says Canada so interface process must be compatible with SABHRS because checks will print.

- Finance returns invoice to Medical Team for entry of funds to be paid in Claim Center.
- Medical Team will pay at the currency rate in effect on the date of service.

33.6 Interpreter Fees and Rated Life Expectancy

Paying Interpreter bills in Claim Center:
Refer to "**PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER**"

- **S**tep 2 of 3: Enter payment information screen
  - Reserve Line - Medical Details/Loss Adjustment Expense/Contract Adjusters.
  - Service Dates – Enter first date and last date of review.
  - Comment – "Paid Interpreter Fees" or "Rated Life Expectancy"
  - Amount to Post – type in the amount due. Please check figures on bill as they are often incorrect.
- Paper bill and documentation are imaged.

33.7 Legal Bills

Paying Legal bills in Claim Center:
Refer to "**PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER**"

- Step 2 of 3: Enter payment information screen
  - Reserve Line - Medical Details/Loss Adjustment Expense/Legal Fees – SF Legal Contracted.
  - Service Dates – Enter first date and last date of billable hours on legal bill.
  - Amount to Post – type in the amount due. Please check figures on bill as they are often incorrect.
- Paper bill and documentation are hand delivered to Barb King.

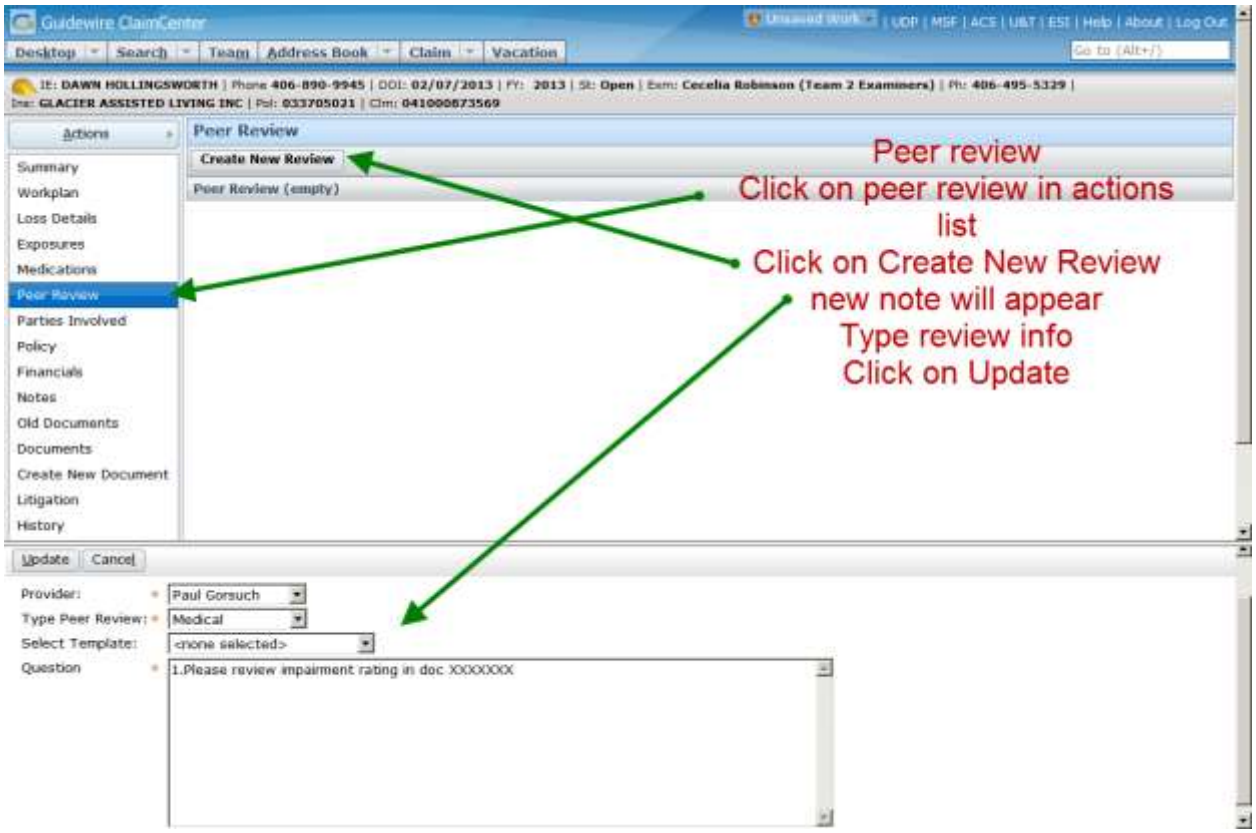
33.8 Medical Consultant Bills (MSF)

CONSULTANT PAYMENT RATES			
CD#/Password	**Rates and Allowances**		**Room**
Gary Blom, DC Chiropractic CD9064	Review Rate	$200.00 p/hr	Desk located in Medical Team area. On-call
Paul Gorsuch, MD Orthopedics CD9101	Review Rate Hotel Allowance Mileage Allowance Meal Allowance	$200.00 p/hr $81.00+tax/night $0.51/mile $23.00/day*	Desk located in Medical Team area. On-call
Ken Carpenter, MD Orthopedics CD9135	Review Rate	$200.00 p/hr	Desk located in Medical Team area. On-call
W. Lea Gorsuch, MD Upper Extremity C95925	Review Rate	$200.00 p/hr	Desk located in Medical Team area. On-call
Lacy Claeys, DDS Dental CD9033/cd9033	Review Rate	$100.00 per review	Desk located in Medical Team area. On-call
Mark Eichler, RPH Pharmacy	Review Rate	$75.00 per review	Call for pick-up
Ronald Hull, MD Pain Mgmt CD9255	Review Rate	$200.00p/hr	Desk located in Medical Team area. On-call

* Daily meal allowance is as follows: $5 morning meal, $6 midday meal, $12 evening meal.

The process for creating and completing a MSF peer review for medical, chiropractic, dental and physical therapy services is as follows:

1. Claims examiner or nurse User will click on "Peer Review" in Actions list, then click on "Create new review". Peer review note will appear. CE or nurse will type review request, then click update.

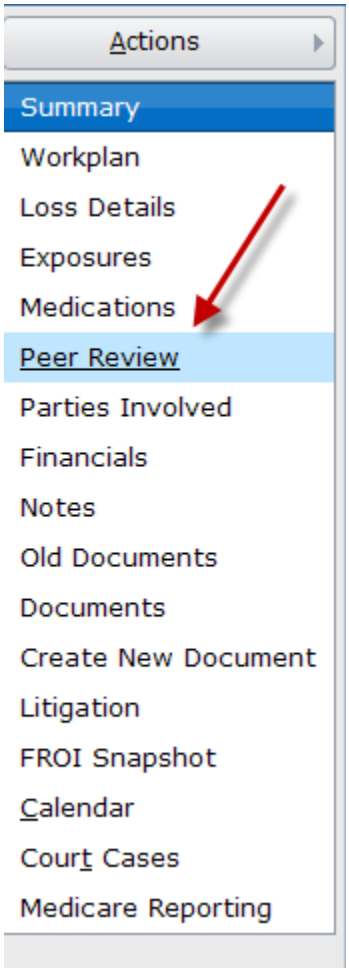


2. This will save in the new Peer Review window. An activity will generate to the reviewer listed in the Peer Review. If the sender wishes to link document(s) to the activity, the user will access the activity and select link documents to link as many as needed.

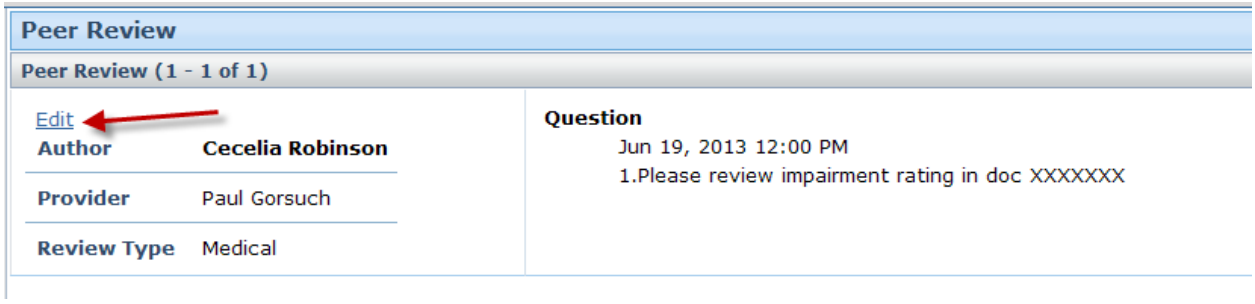
3. The reviewer will click on the claim to open from the CC Desktop.

High	Peer Review Referral	041000873569	DAWN HOLLINGSWORTH	Open

4. Once claim opens, click on Peer Review.



5. Reviewer will read the questions and click Edit to enter the response.



Reviewer may hit Update and save what has been entered. This may be Edited again if needed, **UNTIL** the Activity is Completed.

6. After the reviewer has completed the activity a new activity will generate back to the sender.
7. The Peer Review window will show a history of peer reviews. This information cannot be changed.

8. To track open or completed peer reviews use the use the Search capabilities in Claim Center.
9. Reviewers completing reviews in Claim Center will maintain an excel spreadsheet to track hours and reviews for payment purposes. The medical payment auditors will maintain spreadsheets for the RPh pharmacy reviewer.

The process for creating and completing a MSF peer review for pharmacy is as follows:

RPh Peer

1. Claims examiner or nurse will complete and print the PDF Pharmacy Peer Review Form found on the Portal, Medical Section.
2. Claims examiner or nurse will print pertinent medical records and a current pharmacy report for the injured worker and send to MSF medical payment auditor.
3. Claims examiner or nurse will assign a Peer Review in Claim Center to MSF medical payment auditor who will process to Mark Eichler.

PDRx Review w/ ESI

1. Claims examiner or nurse will obtain approval for review by the Medical Team Leader.
2. Claims examiner or nurse will complete and print the PDRx Referral Form located on the Portal, Medical Section.
3. Claims examiner or nurse will print 3 years of medical records and a the last 12-18 months of prescriptions for the injured worker.
4. Claims examiner or nurse will provide all records to MSF pharmacy liaison for processing to ESI.

- Peer Review Provider will access Claim Center. A list of all open referral activities will display in the Desktop-Activities Page. Reviewer will select the activity they are ready to address.
- Once the activity is opened, the reviewer will be able to access the document by clicking on the 'view' button within the activity.
- Peer Physician will document findings by saving the document into their own directory by using the 'Save As' functionality. This will allow review comments to be placed on the file. Once the final version has been completed, electronically signed and saved, the reviewer will link the document to the claim.
- Set the activity to 'complete'. Once the reviewer has completed the review process they will click on the 'Complete' button within the activity. This action will automatically generate a Peer Referral Complete activity to the claim owner. This activity will advise the claim owner that the review is complete, and the completed form is in the Documents Page of the claim.
    - Medical payment auditors will image dental and ophthalmology reviews to the claim once returned and set the activity to 'complete'.

Process for paying the completed reviews using the reviewers' spreadsheets:

1. **Open Excel → G: →**Select the appropriate consultant's folder and double click on the file.
   - Enter date of peer review completion in column A
   - Calculate the consultant rates as follows.
     - **Chiropractic, Medical and Physical Therapy consultant's rates** calculate using this formula: add the number of minutes worked in column F divided by 60 minutes = total time worked X $200.00 = total $ earned divided by number of referrals completed = Amount due per individual review.
       - **Travel expense** also needs to be added (if applicable) to the consultant rate by taking the total expense of the hotel, travel and meal expenses and dividing by the total # of referrals completed. This $ is then added to the individual review rate. Note: Travel Expense does cap out at the consultant's contracted allowances and should not be reimbursed over the contracted amount.
     - **Dental peer reviews** are paid at a flat rate of $100.00.
     - **Pharmacy peer reviews** are paid at a flat rate of $75.00.
   - Enter total time in red, above completed referral information, in column F. (Does not pertain to Dental and Pharmacy reviews).
   - Enter Amount due per individual review in column I.
   - Enter date of consultant bill payment in column G.
   - Enter an "x" to indicate that the bills were sent to imaging in column H.

2. To create a peer review bill form, **Open Word → H:\Consultant Bill Forms →** Select the correct billing form and double click.
   - Enter date of review on form.
   - Enter Injured Employee name on form.
   - Enter claim number on form.
   - Enter Amount due on form.
   - Print form.

3. Paying Consultant bills in Claim Center:
   Refer to "**PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER**"
   - Step 2 of 3: Enter payment information screen
     - Reserve Line - Medical Details/Loss Adjustment Expense/Medical Consultants.
     - Service Dates – Enter first date and last date of review.
   - Amount to Post – type in the amount due.
   - Paper bill and documentation are imaged.

33.9 Photocopy Bills

Paying Photocopy bills in Claim Center:
Refer to "**PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER**"

- Step 2 of 3: Enter payment information screen
  - Reserve Line - Medical Details/Loss Adjustment Expense/Photocopy Fees.
  - Service Dates – Enter first date and last date of photocopy bill.
  - Amount to Post – type in the amount due. Please check figures on bill as they are often incorrect.

- Paper bill and documentation are imaged.

33.10 Private Investigator (PI) Bills

Paying Private Investigator bills in Claim Center:
Refer to "**PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER**"

- Step 2 of 3: Enter payment information screen
    - Reserve Line - Medical Details/Loss Adjustment Expense/Private Investigator.
    - Service Dates – Enter first date and last date of surveillance.
    - Amount to Post – type in the amount due. Please check figures on bill as they are often incorrect.
- Paper bill and documentation are hand delivered to Tom Disburg.

33.11 Injured Employee Travel

Travel Vouchers for Injured Employees are paid through Claim Center by the Claim Examiner.

33.12 Temporary Purchase Order (TPO)

Air Travel will be paid by the Claim Examiner. They will need to:

- Fill out TPO form.
- Send the white copy to imaging.
- Pay the vendor through Claim Center.

33.13 IE Reimbursement and Prepayments

Paying IE Reimbursements and Prepayments bills in Claim Center:
Refer to "**PROCEDURE FOR ENTERING BILLS IN CLAIM CENTER**"

- Step 2 of 3: Enter payment information screen
    - Reserve Line - Medical Details/Choose the appropriate Cost Category.
    - Service Dates – Enter first date and last date of service rendered.
    - Amount to Post – type in the amount due.

SECTION III – MEMOS AND LETTERS

April 7, 2006

Janet Whitmoyer, RN
Montana Medical Association
2021 Eleventh Avenue
Helena, MT 59601-4890

Re: Non-licensed personnel billing for assistant surgeon services

Dear Ms. Whitmoyer,

Thank you for your letter of March 16, 2006 outlining the concerns expressed by some of your members regarding Montana State Fund's policy of not reimbursing for assistant surgeon services when provided by non-physician personnel.

Montana State Fund's decision to deny payment for non-physician personnel providing assistant surgeon services is based on the Administrative Rules of Montana, section 24.29.1532, that defines the use of fee schedules for medical non-hospital services, and section 24.29.1561(2) that limits a provider's services to those which can be performed within the limits and restrictions of the provider's professional licensure.

As you stated in your letter, the intent of CPT modifiers 80, 81, and 82 is to report physician services. Montana State Fund will recognize nurse practitioners and physician assistants that are licensed by the state in which they practice for payment of assistant surgeon services with the modifier 81 (minimum surgical assistant services).

The roles and reimbursement of certified surgical assistants, first assistants, surgical technicians, registered nurses without advanced nurse practice licensing, etc. as an assistant surgeon are not supported by Montana's Administrative Rules, therefore, Montana State Fund will deny reimbursement for these services unless provided by a assistant surgeon who is a physician, physician assistant or advanced nurse practitioner licensed by the state in which they practice using the appropriate modifier.

It is our intent to recoup those payments made to personnel that are not licensed as a physician, physician assistant or advanced nurse practitioner as discussed above for assistant surgeon services for the prior 2 years.

Please call if you have any further questions or concerns regarding this practice. I may be reached at (406) 444-6134, or you may call Bridget McGregor, RN, MHSA, Medical Team Leader at (406) 444-6595.

Sincerely,

Kym Behlmer, LPN, CPC, CPC-H
Medical Auditor

SECTION IV - FORMS

AMBULANCE INSTRUCTION CALCULATING INSTRUCTION SHEET

Note: Only SI "A" codes may be reimbursed.

Air Carrier services are preempted under the federal Airline Deregulation Act of 1978 (ADA) (49 USC 41713(b) which states "a state, political subdivision of a state, or political authority of at least two states may not enact or enforce a law, regulation or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.". The State of Montana does not have the authority to set a fee schedule rate on worker's compensation injured workers that are transported via air carrier under this law. An air carrier company may request a reconsideration based upon this law, in that event, the bill will need to be re-evaluated to pay the remainder of the usual and customary fee that was charged.

Calculating Ambulance Reimbursement

Note: Where the injured worker is when he/she needs to be transported is the deciding factor regarding whether you calculate mileage by the urban base rate or the rural base rate. NOTE: Use rates in effect at the time of transport to calculate reimbursement.

Mileage

NOTE: Rates are based on those effective 12/1/08 through 6/30/13.

A0425 Ground Mileage, per statute mile: $12.45

Urban Base Rate $9.95
Rural Base Rate $9.95

Multiply the number of miles billed by $12.45, then add the appropriate base rate.

Example: 442 miles X $12.45 = $5,502.90 plus base rate of 9.95 = $5,512.85. *As urban and rural base rates are the same the calculation would be the same for either.*

A0435 Fixed Wing Air Mileage, per statute mile: $17.89

Urban Base Rate $11.92
Rural Base Rate $17.89

Multiply the number of air miles by $17.89, then add the appropriate base rate.

Urban – Example: IE was transported from Missoula to Seattle 393 miles x $11.92 = $4,684.56 plus base rate of $17.89 = $4,702.45.

Rural – Example: IE was transported from Helena to Seattle 487 miles x $17.89 = $8,712.43 plus $17.89 base rate = $8,730.32.

A0436 Rotary Wing Air Mileage, per statute mile: $47.66

Urban Base Rate $31.78
Rural Base Rate $47.66

Multiply the number of air miles by $47.66, than add the appropriate base rate.

Urban – Example: IE was transported from Missoula to Seattle 393 miles x $31.78 = $18,730.38 plus base rate of $31.78 = $18,7623.16.

Rural – Example: IE was transported from Helena to Seattle 487 miles x $47.66 = $23,210.42 plus $47.66 base rate = $23,258.08.

Life Support Services

These are additional services provided in conjunction with the transport of an IE. There are 2 base rates for these services: Urban and Rural. The amounts listed for each code is added to the

total mileage sum for the total reimbursement for ambulance services in addition to any other SI "A" codes that may also be billed using the Facility Fee Schedule or 75% of U@C if there is no fee schedule listed.

Note: Where the injured worker is when he/she needs to be transported is the deciding factor regarding whether you the urban base rate or the rural base rate.

A0426 Ambulance service, advanced life support, non-emergency transport, level 1 (ALS).

Urban Base Rate	$339.61
Rural Base Rate	$339.61

A0427 Ambulance service, advanced life support, emergency transport level 1.

Urban Base Rate	$537.70
Rural Base Rate	$537.70

A0428 Ambulance Service, basic life support, non-emergency transport (BLS).

Urban Base Rate	$283.00
Rural Base Rate	$283.00

A0429 Ambulance service, basic life support, emergency transport (BLS-Emergency).

Urban Base Rate	$452.80
Rural Base Rate	$452.80

A0430 Ambulance service, conventional air services, transport, one way (fixed wing).

Urban Base Rate	$3,876.58
Rural Base Rate	$5,814.86

A0431 Ambulance service, conventional air services, transport, one way (rotary wing).

Urban Base Rate	$4,507.07
Rural Base Rate	$6,760.62

A0432 Paramedic intercept (PI), rural area, transport furnished by a volunteer.

Urban Base Rate	$495.24
Rural Base Rate	$495.24

A0433 Advanced life support, Level 2 (ALS 2)

Urban Base Rate	$778.24
Rural Base Rate	$778.24

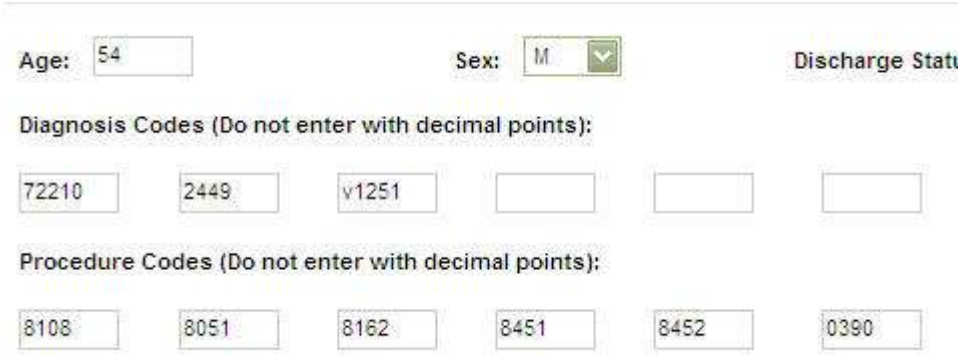
A0434 Specialty care transport (SCT)

Urban Base Rate	$919.74
Rural Base Rate	$919.74

MS-DRG Calculation Instructions

Note: For purposes of this document, Claim Shop is the resource used for indentifying the MS-DRG **only**. The Department of Labor & Industry website is used for the weight associated with the MS-DRG.

1. Go to http://cs1.claimshop.net/grouper_demo/grouper_main.aspx.
2. Enter IE age, sex and discharge status.
3. Enter the diagnosis code(s) found in field locator 68 (system will take up to 9).
4. Enter the procedure code(s) found in field locator 74 (system will take up to 6).



5. Click on Group and Compare. This action will give you the numerical MS-DRG assignment:

CMS v26 (MS FY2009) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)

6. Go to the Department of Labor & Industry website (http://erd.dli.mt.gov/) and choose the Montana Facility Fee Schedule.
7. Click to continue, then click "I accept".
8. The screen shown will be the most current fee schedule in effect. The fee schedule you will use depends on the date of service. **Note:** If the date of service is prior to the effective date of the current fee schedule, go to (i) Facility Fee Schedule Archives.
9. Click on *The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee*. "Find" the MS-DRG listing and use the Relative Weight listed, multiply by the correct base rate (also known as the conversion factor). This will give you the base reimbursement rate for the hospital stay. There are 2 outlier situations that can affect payment:
    a. Outlier threshold – if the reimbursement amount X 3 is less than billed amount.
    b. Implant outlier – if the ***COST*** of the implant(s) (see definition of implant) is $10,000.00 or more.

To calculate Outlier threshold:

1. Multiply the reimbursement x 3. If it is less than the billed amount, subtract that sum from the billed amount and that is the outlier overage.

2. Find the Ratio of Cost to Charges (RCC) - (f) *The Montana RCC and other Montana RCC-based Calculations*) on the DLI website associated with the facility you are calculating the payment on and add .15.

3. Take that figure and multiply it by the above sum.

4. Add this sum to the base MS-DRG reimbursement amount. This will be the total reimbursement allowed.

To calculate the Implant outlier:

1. Invoices are required to qualify for the additional payment. Per ARM 24.29.1432(11)(e)(ii) "Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice, plus the handling and freight cost for the implantable, plus 15 percent of the actual amount paid for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately."

2. You will need to verify the implanted items on the invoice with the operative report to substantiate the implants billed.

3. Add the amounts listed on the invoice(s) for each implant item and total it.

4. For handling and freight, depending on how the invoice is documented, you may need to calculate out the amount of applicable to this bill (ie; if there are 10 items on the invoice listing and only 1 is applicable to the bill you are calculating, you would divide the handling and freight by the number of items on the invoice. Note: Some providers calculate it according to the cost of each implantable).

5. Multiply the implant cost total X 15%, and add the handling and freight applicable to that amount. This will be the Implant Outlier amount. Add this sum to the base reimbursement.

Note: For purposes of Outlier threshold, when the Implant outlier threshold is met, the billed amount of the implant(s) must be subtracted from the total billed amount. If the Outlier Threshold is still met, then both would be added to the base reimbursement total.

Montana State Fund

ACS - Request for Reconsideration

Injured Worker:
Claim #:
Provider:
DCN #:
Request Date:
Initials of Requestor:

Date of Service	***Code***	***Bill Charges***	***Original Allowed Fees***	***New Allowed Fees***	***Additional Payment/or recoupment* Amount***
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
Total Amount due provider:		$0.00	$0.00	$0.00	$0.00

***Note: if amount is in parentheses ( ), it indicates a recoupment is being requested on that line.**

Comments:

_____ Clean claim, please review and reprocess.
_____ Additional documentation submitted.
_____ Do not dup out against other bills.
_____ Provider submitted corrected claim. Please review and reprocess.
_____ Recoupment Request - see instructions below.
_____ Attorney not asserting Lockhart, please process to recoup both provider and attorney pymts.
_____ Payment to provider only, previous Lockhart.
_____ Additional Payment due -see instructions below
_____ VOID Request - provider returned payment. Check # _____

_____Other:

INSTRUCTIONS:

Montana State Fund

ACS - Request for reconsideration of CorVel processed bills.

Injured Worker:
Claim #:
Provider:
Site/Bill #:
Request Date:
Initials of Requestor:

Date of Service	***Code***	***Original Bill Charges***	***Original Allowed Fees***	***New Allowed Fees***	***Amount Due***
			$ -		
			$ -	$ -	$ -
			$ -	$ -	$ -
Total Amount due to the provider:					$ -

Comments:

BILL ROUTING FORM

From MSF
Number of boxes sent: Box___of___

MSF Signature: _____Date:_____

Received by ACS
ACS Signature:_____Date:_____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

From ACS
Scan Date:
Number of boxes sent: Box___of___

ACS Signature:_____Date:_____

Received by MSF
MSF Signature: _____Date:_____